MEDICAL INFORMATION

(To be completed by a social worker. You can type directly in to this document. If you submit a completely hand-written application, **PLEASE PRINT**)

Child's Name: _____

Child's Diagnosis: _____

Date of Diagnosis (**Month-Day-Year**): _____

Child's Physician: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Worker's **Direct Phone Number and Extension**: _____

Please describe the child's medical condition, anticipated hospital stay, and any other notable facts (please attach a letter if needed):

Social Worker's Name and Title **(please print)** _____

Social Worker's Hand-Written Signature _____

Date: _____ Social Worker's Email Address **(please print)** _____

* By signing this application, you are attesting to the accuracy of the information on both pages, to the best of your knowledge. Fraudulent applications may result in your institution being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.