LEVEL THE PLAYING FIELD
EDUCATION - ASSISTANCE - EMPLOYMENT

APPLICATION FOR POTENTIAL RECIPIENT

Case Number:_____
For LTPF Use

*All fields are required to be completed, if not applicable, please enter n/a
*Verification may be requested

Date of Submission*:_____ LTPF Member Name:_____

How did you learn about Level the Playing Field*:_____

Potential Recipient Information:

Potential Recipient's Name*:_____Age*:_____

Recipient's Diagnosis*:

Treatments and Therapies receiving*:

Have we ever helped this child and/or family before? ☐Yes ☐No

If YES: What did we do*

Family Information:

Parent/Guardian Name*:_____

Email Address*:_____Relationship to Recipient*:_____

Address*: Street_____ City_____ State_____ Zip_____

Contact Phone*:_____

Employment Status Parent(s)/Guardian(s)*: MOTHER ☐Yes ☐No FATHER ☐Yes ☐No

If EITHER IS YES:

Name of ALL Employer(s)*: _____

How many hours per week*: _____ TOTAL Annual household income*: _____

List ALL OTHER Sources of Income and Assistance (List State and Federal Assistance and any other income sources, including online fundraising like GoFundMe)*:

_____

Rent/Mortgage:_____ Utilities: _____ Car: _____ Cell:_____

List OTHER Monthly Bills: _____

Application Submission Information:

Relationship to Recipient*: ☐Parent/Guardian ☐Social Worker ☐Advocate ☐Other

If NOT Parent/Guardian, complete the following:

Your Name*:_____Email Address*:_____

Contact Phone*:_____Relationship to Family*:_____

Are you also working with either: ☐Advocate ☐Social Worker

If EITHER:

Name*:_____ Email Address*:_____

Contact Phone*:_____

Does the Parent/Guardian speak and understand English*: ☐Yes ☐No

If NO, YOU will need to supply an interpreter at our interview.

What Assistance Are You Requesting:

Select All That Apply*:

☐Medical Bills ☐Equipment/Therapies ☐Household Bills ☐Transportation

What is the total cost*_____

Detailed Description of Assistance Requested (provide an estimate if possible) *:

Insurance Information:

Will any part of this item be covered by insurance*: ☐Yes ☐No ☐Unsure

If YES:

Insurance Carrier Name*:_____

How much will insurance cover* _____

Medical/Therapy Provider Contact Information:

Name*: _____

Address*: Street_____ City_____ State_____ Zip_____

Contact Phone:_____Email: _____

Primary Care Physician Name*: _____ Contact Phone*:_____

Hospital*:_____

Availability to meet by video: (Pick all applicable): ☐ Morning ☐ Afternoon ☐ Evening

Approved: ☐Yes ☐No Date _____

Amount: _____

For LTPF Use