



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: _____

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