Thomas P. and Sondra D. Sheehan Charitable Foundation
Financial Assistance Application

Date submitted*:*

APPLICANT CONTACT INFORMATION:

Name:	
Mailing Address:	
City, State, Zip:	
Telephone:	Cell:
Applicant Signature:	

FINANCIAL EVALUTATION SUMMARY:. *Referring Healthcare facility to complete this section.*

REFERRING HOSPITAL CONTACT INFORMATION:

Hospital Staff Contact Name:	
Title:	
Contact Telephone:	Contact Fax:
Contact Email:	

Patient meets critieria for financial assistance program of referring hospital? Yes: No:

Patient has given approval for referring hospital to release financial information? Yes: No:

Date approved by referring hospital:

Approved services/ items are rendered by a approved provider? Yes: No:

GRANT REQUEST SUMMARY: *In the expandable cells below, provide an explanation of need.*

A. **Total cost of the proposed services/items** $
B. **Total dollars covered by other sources** $
C. **Request to the Foundation** $

1. Briefly describe your child's medical condition.

2. Describe the medical treatment, medical therapy, etc. your child's doctor has specifically prescribed.

3. What specific impact does the child's medical condition(s) have on the child's life? (This may include medical, social, mental, etc.)

4. Has the child received the prescribed therapy, treatment and/or medical services before? If yes, have they been effective?

5. Please provide the child's primary care medical doctor name, phone number, and mailing address.