



For Office Use Only	
Cheque No	
Amount Funded	
Date	

APPLICATION FOR ASSISTANCE

Date of Request Amount of Request

Child's Name Age

Address

City Postal Code

Home Telephone Number Email Address

Mother's Name Business Telephone

Father's Name Business Telephone

Medical Diagnosis (Please Attach Verification)

Reason for Request

What goals are you hoping to achieve?

Name/Address/Telephone Number of the Company or Individual Who Will be Providing the Service or Item (Please Attach an Official Quote or Proof of Payment)

What Other Organizations Have you Applied to For Funding? What Was the Response? (Note: Confirmation Required)

Do you receive special services at home? YES NO

Do you receive Assistance to Children With Severe Disabilities (ACSD)? YES NO

Do you have extended health benefits through your employer? YES NO

I certify that the information in this form is true and complete and does not contain a claim for any expenses previously paid for by this or any other organization. I authorize For the Love Of a Child, its Agents and Service Providers to use and exchange information needed for approving this request.

Signature: _____

Date: _____

As you are aware, For the Love of a Child is a non-profit organization that depends on volunteers. Would you be willing to volunteer for our organization? YES NO

If YES, do you have any special skills? (i.e. Fundraising, Accounting, Printing etc.)
