Thomas Cellini Huntington's Foundation

3019 East End Avenue / South Chicago Heights, IL 60411 / 708-756-7100

ASSISTANCE REQUEST FORM

Office Use Only: Date ___/___/___ Request received by: __Director __Assistant __Board Member _____

ALL SECTIONS MUST BE COMPLETED:

Requested by:_____

Relationship to recipient: ☐ Self ☐ Spouse ☐ Child ☐ Sibling ☐ Friend ☐ Case/Social Worker

Recipient Name:_____ Birthdate ___/___/___ # of dependents_____

Income Range: ☐ 0 - $30,000 ☐ $30,000-$60,000 ☐ $60,000-$90,000 ☐ $90,000 or more

PRIMARY CONTACT INFO:

Name:_____Contact: ☐ Recipient ☐ Requested by

Address: _____City_____St___ Zip_____

Phone: _____Email _____

CASE WORKER, MOVEMENT DISORDER CLINIC or PHYSICIAN INFO:

☐ Case Worker ☐ Movement Disorder Clinic ☐ Physician

Name:_____Agency_____

Address: _____City _____St___ Zip_____

Phone: _____ Email _____

I authorize the release of information to the Thomas Cellini Huntington's Foundation. ☐ Yes ☐ No

☞ Sign here_____ Date _____/_____/_____

FAMILY HISTORY

Family Members with HD: ☐ Self ☐ Mother ☐ Father ☐ Sibling #_____ ☐ Children #____

HD PROGRESSION AND CURRENT STATUS INFORMATION:

_____

_____

_____

_____

DESCRIPTION OF ASSISTANCE REQUEST: Estimated Costs of Services/Items Needed **$**_____

_____

_____

_____

_____

Status:

Presented to Board _____/_____/_____ Status: ☐ Approved $_____ ☐ Denied ☐ Pending

Next Action Item(s):

_____

_____

_____

_____

Date	Contact with	Notes