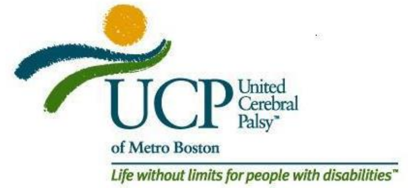


# United Cerebral Palsy of MetroBoston
# Application for Financial Assistance

Name of Applicant ______________________ Date of Birth ________________

Parent Guardian ______________________ Home Phone ________________
(If applicant is under the age of 18)

E-mail address ______________________ Cell Phone ________________

Address ____________________________________________________________
Street City State Zip Code

Referred by ______________________ Contact Number ________________

Service or item requested ______________________________________________

Brief description of applicant and how he or she will benefit from the item or service requested:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

This service or item was ordered or recommended by:

☐ Physician ☐ Occupational Therapist ☐ Physical Therapist

☐ Teacher ☐ Other ______________________________________

Cost of item or service $______________ What portion of cost can you pay? ______________

Where will item or service be obtained? ______________________________

Address and telephone of Supplier ______________________________
______________________________________________________________

Are you receiving funding from any other agency for this item? ☐ YES ☐ NO

Name of Funding Source(s) ____________________________________________
____________________________________________________________

Contact Name and Number ____________________________________________

Anticipated or actual amount to be obtained ______________________________

Please attach or write as much information as possible about the item or service you are requesting such as brochure, product description from print or on-line catalog, etc. including something which indicates the cost of the item or service.

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Please note that UCP may request additional information before a decision can be made regarding your request for financial assistance.

To the best of my knowledge, the above information is complete and accurate.

______________________________________ ____________________
Signature of Applicant or Guardian Date

For UCP Use Only

Date received: ____________________

Application ☐ Accepted (Amount approved: $____________________)

☐ Denied (Reason: ______________________________)

Signature: ______________________________ ____________________
Family Support Director *Date*

Signature: ______________________________ ____________________
Chief Executive Officer or Designee Date

Return completed application to:
UCP of MetroBoston, Financial Assistance, 71 Arsenal Street, Watertown, MA 02472.