BENEFICIARY REFERRAL & REQUEST

The ATI Foundation is committed to aiding children with physical impairments, in need of medical resources and funding to enhance and sustain a better quality of life.

Date of Application: _____

Beneficiary Name: _____ Age:_____

Parent(s) or Legal Guardian(s) Name:_____

Medical Condition:_____

Your Information

Name:_____ Email: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

When is the best time to reach you? _____

Relationship to Child:
- ☐ Parent/Legal Guardian
- ☐ Family Member (other than parent)
- ☐ Neighbor
- ☐ Family Friend
- ☐ Medical Professional
- ☐ Other: _____

Is there an account set up to make a donation to/for the beneficiary? If yes, please provide the appropriate information:_____

_____

_____

Potential Beneficiary Information

Beneficiary Biography—the longevity of the beneficiary's medical condition and any other information you would like us to know about their condition. Please also cite the medical expenses and/or resources the funding from the ATI Foundation is needed for, providing actual numbers is helpful, if known: (*please use separate page as needed)* _____

We would like to learn more about the family of the beneficiary. If applicable, please include the number of children in the family and anything else you would like us to know about the family situation. (*please use separate page as needed)*