

KELLY ANNE DOLAN MEMORIAL FUND
P. O. Box 556 * Ambler PA 19002 * Phone: 215-643-0763 * Fax: 215-628-0266
www.kadmf.org

Data Form

The data **must be typed** or **hand printed clearly** and accompanied by a **typed** one page Cover Letter on hospital/agency letterhead providing confidential **patient medical information, family situation and reasons for referral** from a social worker or other healthcare professional.

This Request Date: _____ Previous Request Date: _____

Patient's Name: _____ Birth date: _____ Race: _____

Please circle the caregiver below & give the full name (both parents names if they are married or living together):

Parent(s), Guardian(s), Grandparent(s), or Foster Parent(s) Name: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone: _____ Annual Family Income Estimate \$ _____

Employed Father/Mother/Caregiver: Yes _____ No _____ Single Parent: Yes _____ No _____

Has caregiver left work or reduced hours because of child's illness: Yes _____ No _____

Number & ages of siblings **living at home**: _____

Referring Social Worker/Case Manager Name: _____

Hospital/Facility or Social Service Agency: _____

Address: _____

Phone: _____ Fax: _____ email: _____

Amount of Request \$ _____ Request for: _____

(Electric bill, Gas bill, Rent, etc.)

PLEASE INCLUDE COPY OF BILL (S) :

Check payable to, Name: _____

Receiver Address: _____

City: _____ State: _____ Zip: _____

Account number: _____

Phone number (if applicable): _____



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Guidelines for Referring Social Workers & Other Health Care Professionals

To enable us to process your requests promptly, please mail or fax
(if you fax the information, please do not mail a second copy):

1. **A typed Cover Letter** on your office letterhead no longer than one page stating medical diagnoses, physical condition of the patient, family's financial situation, reasons for referral as well as what the request is for. *In order to qualify, the child must be medically involved, i.e., currently or recently hospitalized at the time of your request, or receiving ongoing medical treatment at a medical facility or at home through specialized nursing care.*
2. A typed or hand printed (clearly) Dolan Fund's **"Data Sheet."** *Please be sure to provide all requested information or we would be unable to process your request. Please **type or hand print** clearly the Data Sheet since it is often difficult to read faxed names, addresses and account numbers with accuracy.*
3. **Copies of all bills to be paid.** *Please fax us **only** the part that says "Return with payment"*

Fund's Mission: *The KADMF is dedicated to the uninsured needs of families caring for terminally, critically and chronically ill and physically challenged children through advocacy, financial assistance, education and informational resources.*

Thank you,
Vani Kumar, Program Coordinator