Children's Hope New Client Form
Application for Assistance

Office: 505.787.2143 / **Fax:** 888.976.7711
Physical Address: 1503 Schofield Lane, Farmington, NM 87401
Email: info@thechildrenshope.org

Child's Name: _____ **Gender:** _____

Date of Birth: _____ **Ethnicity:**_____

Father's Name:_____ **Mother's Name:**_____

Phone: (c)_____ **(h)**_____

Mailing Address:_____

Street/Box #_____

City:_____**State:**_____**Zip:**_____

Email:_____

Medical Diagnosis: _____

Appointment Date: _____

Name of Facility: _____ **City, State**: _____

(For Office Use Only)

Card Given:_____ **Amount**: _____

Other Assistance: _____ **Amount**: _____

Please attach a referral letter from a medical professional in regard to treatment plan.

Does a referral accompany this application? _____Yes _____No

Name of professional making this referral:_____
Office/Organization/Clinic:_____
Contact Phone Number:_____Fax:_____
Referring Professional's Signature:_____

Parent/Guardian Signature: _____

Date: _____ **Staff Signature**: _____