Larrabee Fund Association, Inc. of Greater Hartford
Cover Sheet

Forms must be typewritten. Mail this Cover Sheet, the Financial Form, the Client Information Form, and ALL supporting documentation, to your Larrabee Board representative or to Larrabee Fund, PO Box 271724, West Hartford, CT 06127. All forms and documentation must be **received** by a Larrabee Board member by **the third Tuesday of the month** to be considered at the following month's Board meeting.

Date _____

Client Name _____

Social Worker Name, Agency _____

Social Worker Phone, Email _____

For **One Time Requests**: If multiple requests/bills are being submitted, please list separately

Purpose of Request	Amount	Payable to	Bill Enclosed		If no bill or other documentation, **provide name, address, account number and any other information necessary to ensure check reaches correct entity**.
			yes	no	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
	$ 0.00		☐	☐	

For **Monthly Stipend Requests**: May be granted for up to six months.

Purpose of Request	Amount	Payable to	Bill Enclosed		If no bill or other documentation, **provide name, address, account number and any other information necessary to ensure check reaches correct entity**.
			yes	no	
			☐	☐	
			☐	☐	
	$ 0.00		☐	☐	

How many months do you anticipate the client needing support? _____ Months

If additional sources of support have been or will be sought for this request, identify source and status of request.

Source	Status of Request

 Fillable Forms may be downloaded from Forms Section at www.larrabeefund.org

Larrabee Fund Association, Inc. of Greater Hartford

Financial Form

Client Name _____ Date _____

Address _____

City, State _____ Zip _____

Age _____ Marital Status _____ Children _____ Dependents _____

Referred by (Name, Agency) _____

Major Medical Problems (Please limit to 3) _____

INCOME

TYPE	MONTHLY AMOUNT
Social Security	
Disability	
Pension	
Employment	
Other: Please describe	
TOTAL	$ 0.00

EXPENSE (MONTHLY)

TYPE	AMOUNT
Rent	
Mortgage payment	
Utilities (Heat, Electricity)	
Phone	
Cable/Internet	
Transportation	
Medical	
Prescription	
Groceries	
Clothing	
Health Insurance	
Other Insurance	
Other: Please describe below	
TOTAL	$ 0.00

ASSETS

TYPE	VALUE
Savings	
Checking	
Investments	
Home (estimated)	
Vehicle (estimated)	
Other: Please describe below	
TOTAL	$ 0.00

DEBT

TYPE	AMOUNT
Mortgage	
Credit Card	
Car Loan	
Other: Please describe below	
TOTAL	$ 0.00

PURPOSE OF REQUEST

_____

_____

_____

CLIENT SIGNATURE

_____

SOCIAL WORKER SIGNATURE AND DATE

_____

_____

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Larrabee Fund Association, Inc. of Greater Hartford
Client Information Sheet

Please type your answers.

Client _____

1. Is the client NEW to Larrabee? ☐ YES ☐ NO
   1.a. Date of most recent prior application, and action taken. Month /Year:_____
   Action:_____

2. Please provide background and any additional information relevant to this request.

_____

_____

_____

_____

_____

_____

_____

3. What is the plan to sustain the client when Larrabee funding ceases?

_____

_____

_____

_____

4. List any public assistance programs the client is on.

_____

5. List any health insurance plans which provide coverage for the client.

_____

6. Have you and the client discussed health insurance options available pursuant to the Affordable Care Act?
   ☐ YES ☐ NO