Dolphin Assisted Therapy Program Assistance Application

Instructions: Please complete this form entirely.
Upon completion please return by fax, email, or mail to: The Dr. John E. Upledger Foundation
11211 Prosperity Farms Road, D-223, Palm Beach Gardens, FL 33410
Phone: 561.622.4588 • **Fax**: 561.627.9231 • **Email**: info@upledger.org

To apply, you or a loved one must meet the follow criteria: Be a US resident and currently receiving active treatment or ongoing medical follow up for a condition known to be benefited by hands on therapy. The JEUF Assistance Program may offer a variety of complementary treatment modalities at a significantly reduced or no fee basis, based on individual need. Assistance is based on fund availability.

Today's Date: _____

Client First Name: _____ Last Name: _____ DOB: _____

(*If client is less than 18 years of age):*

Parent/Guardian First Name: _____Last Name: _____

Address: _____Apt #_____

City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

How did you hear about the Assistance Program? _____

_____

What are your top three treatment needs?

1. _____

2. _____

3._____

Do you have health insurance? Y / N If yes, please list your current provider: _____

_____

Do you have Medicaid (Title 19)? Yes No

To be completed by the clients prescribing healthcare provider.

Healthcare Provider Name: _____License #: _____

Client Diagnosis: _____Date of Diagnosis: _____

Is Patient in Active Treatment and/or Ongoing Follow-Up? Yes No

Hospital/Clinic: _____

Address: _____

City: _____State: _____Zip: _____Phone: _____

Healthcare Provider Signature _____ Date: _____

_____ _____

Client or Parent/Guardian Signature **Date**

For JEUF Office Use Only:

Date Received: _____Received by: _____

Comments: _____

_____