Larrabee Fund Association, Inc. of Greater Hartford
Stipend Review Form

Forms must be typewritten. Mail this Stipend Review Form, with the Financial Statement Form and any documentation, to your Larrabee Board representative or Larrabee Fund, PO Box 271724, West Hartford, CT 06127. All forms and documentation must be **received** by a Larrabee Board member by **the last Tuesday of the month** to be considered at the following month's Board meeting.

Date _____

Client Name _____

Current Stipend ☐ Date Began/Last Renewed ☐

Major Medical Problems When Stipend Began/Last Renewed:

_____

_____

Current health status is: ☐ Same ☐ Better ☐ Worse

Why should Stipend be continued? Please give details about **current** medical problems and other mitigating circumstances:

_____

_____

_____

_____

_____

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

_____

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

Referred by (Name, Agency) _____

Social Worker Telephone and Email _____

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	

ASSETS

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

DEBT

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

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	

PURPOSE OF REQUEST

CLIENT SIGNATURE

SOCIAL WORKER SIGNATURE AND DATE