

REQUEST FOR ASSISTANCE

Healthcare Grant _____

Loaned Equipment _____

CHILD'S INFORMATION:

Name: (Last/First/Middle) _____

Address _____

City _____ State GA Zip _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Height _____ Weight _____

Diagnosis _____

Diagnosis made by _____

Date of Diagnosis _____ Resident of the State of Georgia? Yes No

U.S. Citizen? Yes No

FAMILY INFORMATION:

Circle: biological parents adoptive parents foster parents grandparents

Parent(s)/Guardian(s) _____

Home Telephone: (____) _____ E-mail _____

Parent(s)/Guardians(s) Date of Birth _____

Number of children in family _____ Ages _____ Do you own or rent your home? Own Rent

Who is your child's primary care giver? (On a day-to-day basis, do not list primary care physician)

Name(s) and relationship(s) of other care giver(s) _____

Other than parents, do any other adults reside in home (18 years or older)? _____

If yes, relationship to child _____

EMPLOYMENT INFORMATION:

Parent/Guardian _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Employer's Phone (_____) _____ Date of Hire _____

Position _____ Supervisor's Name _____

Spouse or Other Domestic Partner _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Employer's Phone (_____) _____ Date of Hire _____

Position _____ Supervisor's Name _____

Do you receive any additional sources of income (AFDC, SSI, WIC, Child Support, etc.)? Yes No

If yes, please list _____

Income (***include copy of last tax return***):

- | | |
|------------------------|--------------------------|
| ____ Below \$15,000 | ____ \$75,001-\$100,000 |
| ____ \$15,001-\$30,000 | ____ \$100,001-\$125,000 |
| ____ \$30,001-\$50,000 | ____ Above \$125,000 |
| ____ \$50,001-\$75,000 | |

Have you received monetary damages from a lawsuit? _____ If yes, please explain:

INSURANCE INFORMATION:

Name of Insured _____

Insurance Company _____ Policy No. _____

Medicaid No. _____

MEDICAL INFORMATION:

Full name(s) of primary physician(s) presently involved in child's care _____

Area Code (_____) _____

Full name(s) of secondary physician(s) presently involved in child's care _____

Name of hospital involved with child's care _____

Child's regular diet and means of eating _____

Is child oxygen dependent? Yes No Is child ventilator dependent? Yes No

Name of child's current therapist outside of home:

Physical _____ Area Code (_____) _____

Occupational _____ Area Code (_____) _____

Speech _____ Area Code (_____) _____

Name of social worker(s) (hospital, school, Medicaid, Babies Can't Wait or other agency) involved with child's care _____

Name of school or day care program that child is currently involved in _____

Area Code (_____) _____ Contact Name _____

WHEELCHAIR INFORMATION:

Is your child wheelchair dependent? Yes No

[If “yes”, please complete the remainder of this section. If “no”, go directly to “Parent’s Request”].

Type of wheelchair used? (Brand Name/Model) _____

Manual? Motorized?

PARENT’S REQUEST:

Type of assistance requested _____

Reason for requesting assistance _____

The Foundation wants parents to know about and use all of the resources that are available to their child. In the appropriate space, be sure to mention all of the organizations and programs you have contacted concerning not only your current needs but also previous needs. The Foundation may be able to provide you with information about other available resources.

What type of Financial Assistance has the parent previously sought to obtain? (list all organizations)

What additional sources (other than this request) does the parent intend to pursue? (other organizations, loans, etc.) _____

Have you received additional help from any organizations in the past year? If yes, please list all help received. _____

Please provide any additional information you believe would be beneficial in evaluating this request.

How did you learn about Fragile Kids Foundation? (Please be specific) _____

Signature of Parent or Guardian

Date _____

Fragile Kids Foundation does not discriminate against nor deny aid to any applicant because of race, religion, color, national origin, sex or political affiliation.

This portion of the application contains information that will be used to assure our outreach is serving a diverse community within the state of Georgia. This information will **NOT** be used during the Review Process to evaluate the application.

Ethnicity:

_____ White/Caucasian

_____ Black or African-American

_____ Hispanic

_____ Asian or Pacific Islander

_____ American Indian/Native American

_____ Other

County: _____

Consent to Release Information

Name of Child _____

I do hereby authorize all hospitals, physicians, financial institutions, insurance groups, or other professional staff persons to release to Fragile Kids Foundation, or its duly authorized representative, any information deemed necessary to complete its investigation on my application for assistance.

Signature or Parent or Guardian _____

Street Address _____

City _____ State _____ Zip _____ County _____

Area Code (_____) Phone Number _____ Date _____

Fragile Kids Foundation
Letter of Medical Necessity
(To be completed by the child's physician or therapist)

Child's Name: _____

Diagnosis: _____

Equipment Requested

(Please include full description of product, manufacturer, model, size, accessories). Attach product brochure and price quote.

Child's functional abilities:

Goals to be accomplished within 12 months using this equipment:

This is deemed medically necessary by:

Name _____

***Attach Business Card of Physician or
Therapist here***

Title _____

Signature _____