HELPING FAMILIES FACING MEDICAL CHALLENGES DO MORE!

APPLICATION FOR FINANCIAL ASSISTANCE

The Do More Foundation exists to assist families with financial needs as a result of the death or illness of a child.

Child's Name _____DOB _____ Gender M F

Diagnosis _____

MOTHER'S PERSONAL INFORMATION

Mother's Name _____Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____Email _____

Current Employer _____

Position _____

Employer Address _____

City _____ State _____ Zip _____

Contact Person _____ Business Phone _____

Housing: Rent _____ Own _____ Other _____ Number of people in household _____

FATHER'S PERSONAL INFORMATION

Father's Name _____Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____Email _____

Current Employer _____

Position _____

Employer Address _____

City _____ State _____ Zip _____

Contact Person _____ Business Phone _____.

Housing: Rent _____ Own _____ Other _____ Number of people in household _____

If your child is currently inpatient, please fill out this section:

Hospital name _____City _____

Is this hospital within 25 miles of your primary residence? _____ If no, how far? _____

What is the estimated length of stay for this hospitalization? _____

Diagnosis _____

Social Worker Name _____ Phone Number/Email _____

If your child is receiving outpatient treatment, please fill out this section:

Please describe the type of outpatient care your child is undergoing -

_____

_____

_____

_____

What is the estimated length of time for this treatment?

_____

_____

How often is child receiving treatment at a hospital facility? _____

_____

What type of care is administered at home? How often?

_____

_____

Please describe the specific financial need you are seeking help with (Describe in detail)

_____ Housing Expenses (Rent, mortgage, etc.)

_____ Meal Expenses

_____ Transportation Costs (Gas, air travel, etc)

_____ Uncovered Medical Bills

_____ Equipment for Therapy

_____ Medical Supplies

_____ Other

_____

_____

_____

_____

Amount you are requesting _____

Have you received other financial assistance?

_____ Fundraisers

_____ Church donation

_____ Other organization

_____ Government Assistance

_____ Other

If yes, please explain in detail (**include dates assistance was granted**, **amount and if this assistance is ongoing)**

Financial Information

Annual Household Gross Income _____

Source of Income: _____ Job _____ Government Assistance (Please explain) _____ Other (Please explain)_____

_____

Please explain how a grant from The Do More Foundation would assist your family-

_____

_____

_____

_____

Application Agreement

I hereby apply for assistance from **The Do More Foundation** to assist with expenses related to the chronic illness of my child. I attest that the information contained in this application is true and accurate. I authorize **The Do More Foundation** to obtain information from our funeral home pertinent to the application and grant request. I understand that any information that is falsely submitted will disqualify me from receiving financial assistance from **The Do More Foundation.**

Father's Signature _____ Date _____

Mother's Signature _____ Date _____

Media Release

I hereby authorize **The Do More Foundation, Inc**. to use my photographs, letters or information in publications or on the Internet. I understand that these items will be used to educate the public about **The Do More Foundation, Inc.** and its services. I further understand that our last name will not be used in any material. The consents, terms and conditions of this agreement shall continue in effect beyond the date it is signed.

Father's Signature _____ Date _____

Mother's Signature _____ Date _____