Guidelines for families seeking financial assistance

Applications are accepted from any child in the US under the age of 18, any type of cancer diagnosis, and from all income levels. Although Addi’s Faith Foundation strives to help as many families as possible, we simply cannot meet every request and priority is given to Houston area, brain tumor patients, with a high financial need.

For your application to be reviewed, you must submit the following:

- Application that is thoroughly completed by a parent or legal guardian. The more information you can provide the better. *(incomplete applications will not be reviewed)*
- A patient confirmation letter from your doctor or licensed social worker on letterhead explaining the child’s diagnosis, family situation, and treatment plans for the next 60 days.
- Any bills or account statements for which you are requesting assistance.
- Child’s photo. This is not a requirement, but we love to put a face with the name.

**Please mail this application, along necessary documentation, to:**

Addi’s Faith Foundation | 2410 Riverway Oak Drive | Kingwood, TX 77345

**Or submit by email:** info@addisfaithfoundation.org

**Or submit online:** www.AddisFaith.org

*** Please allow 4-8 weeks for a response. ***
Application for Assistance
(Revised 2018)

Name of person completing this application: _____________________________________________________________

Relationship to patient: ____________________________________________ Today’s Date ______________

Child’s Name: ____________________________

Child’s Age: ___________ Date of birth: ___________________ Gender: ___________________

Child’s Diagnosis: ____________________________________________

Date of initial diagnosis: _______________ Relapse date (if applicable) ______________________________

Guardian 1 Name_________________________ relationship to patient ______________________

Guardian 2 Name_________________________ relationship to patient ______________________

Address__________________________________________________________

City________________________________ State_________________________ Zip____________________

Phone Number (home)________________________(cell)________________________

E-Mail Address_______________________________________________________

How many members are living in the household? ___________ Please list their names & ages:

Name____________________ age____ Name____________________ age____

Name____________________ age____ Name____________________ age____

Name____________________ age____ Name____________________ age____

Name____________________ age____ Name____________________ age____
How did you hear about Addi’s Faith Foundation?

__________________________________________________________________________________________

Referral Name: ________________________________ Referral Phone number: ________________________

Referral email: ________________________________

Patient Website (Caringbridge – Blog – Facebook - etc.) Please provide exact address and login information.

__________________________________________________________________________________________

Where is your child being treated? ____________________________________________________________

Approximately, how far is the treatment site from where you live? ________________________________

If you travel for treatment, where do you reside during your stay?

__________________________________________________________________________________________

Please state why you are requesting help from Addi’s Faith Foundation. (attach additional pages as needed)

__________________________________________________________________________________________

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__________________________________________________________________________________________
Specify which area you are requesting assistance for and the amount of each. (AFF will consider requests up to $1500)

- Housing
  - Amount $ _______________

- Utilities
  - Amount $ _______________

- Car Payment
  - Amount $ _______________

- Other (explain below)
  - Amount $ _______________

Other (please explain)
___________________________________________________________

___________________________________________________________

Family Income

Prior to diagnosis:
  - $_____________ monthly  $_____________ annual

Current Income:
  - $_____________ monthly  $_____________ annual

Family income sources (please check all that apply)

  _____Salary   _____SSI   _____Child Support   _____Other

Guardian 1: Employer
___________________________________________________________

  _____ On PAID leave   _____ On UN-PAID leave   _____ Quit job   _____ Reduced hours   _____ Other

(if other, please explain)

___________________________________________________________

Guardian 2: Employer
___________________________________________________________

  _____ On PAID leave   _____ On UN-PAID leave   _____ Quit job   _____ Reduced hours   _____ Other

(if other, please explain)

___________________________________________________________

Have you previously received assistance from Addi’s Faith Foundation? _____ yes   _____ no

If yes, when? ________________________________________________
List any additional organizations you have received assistance from.

_____________________________________________  ____________________________________________

_____________________________________________  ____________________________________________

**Payment Information**

To make a timely payment to your creditor, we need the following details.

Check payable to: _________________________________________________________________

Account number: _______________________________________________________________  _______________________________________________________________

Creditor Address:______________________________________________________________________________

City_________________________State_________________________Zip________________

Creditor Phone: _______________________________________________________________

Please attach account statement, lease agreement or other supporting documentation. We cannot process your request without this information.

**Acknowledgement**

I understand that by signing this application, I give consent to Addi’s Faith Foundation to disclose to the public via television and radio stations, newspapers, websites, magazines, newsletters, social media, as well as in educational and fundraising opportunities, my child’s/my family’s story including child diagnosis, general story, photos, and videos. I understand my child’s name, city, state and hospital or care facility may be used.

I authorize the verifier (healthcare provider, social worker etc.) provided on this form to release information (including diagnosis, treatment status and other pertinent information related to grant request) to Addi’s Faith Foundation as necessary to determine eligibility and processing of this grant request.

I understand that my personal information will not be published or shared with the public or a third party. Personal information is defined as home address, phone number, email address and creditor information.

Name (please print) ________________________ date_______________________________

Signature _____________________________

*Anti-Discrimination Policy: You and your child will not be discriminated against or denied assistance because of your race, religion, color, national origin, gender or political affiliation. All financial applications will be reviewed on a case-by-case basis and final determination will be made based upon your eligibility, AFF guidelines and the availability of funds.*