Addi's Faith Foundation

#addisfaith #endingchildhoodcancer

2410 Riverway Oak Drive | Kingwood, TX 77345
www.AddisFaith.org
info@addisfaith.org

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@addisfaith.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.