



APPLICATION FOR NEED-BASED GRANT

ELIGIBILITY:

- Applicants must be parents or legal guardians of a child who has been diagnosed with and is undergoing testing or treatment for a serious heart-related medical problem.
- Applicants must be facing a financial hardship as a result of travel, lodging, and other expenses associated with the child's medical problem that are not covered by insurance.
- All grants are awarded at the Foundation's discretion on a first come, first served basis. The Foundation may approve an amount lower than the amount requested or deny the request completely.
- Timeliness of payment will be determined by the amount of funds available at the time of application.

APPLICATION INSTRUCTIONS: (incomplete applications will be returned without action)

- Applicants must complete this application.
- Applicants must attached copy of a recent pay stub.
- To the extent possible, applicants must attach proof of expenses incurred. Applicants who cannot pay a cost up front should attach a quote for the estimated amount of the expense. Grant checks are made payable to the vendor on behalf of the applicant and will be mailed to the applicant.
- Mail completed applications to the Erika Kate Foundation, PO Box 262, Muscatine, IA 52761, or fax applications to 563.263.1757.

APPLICANT'S INFORMATION (Please print clearly to speed processing)

Name: _____ Birth date: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ E-mail: _____

Relationship to child: _____ Religion: _____

CHILD'S INFORMATION

Name: _____ Birth date: _____

Illness or medical condition: _____

Year of diagnosis: _____ Gender (circle one): F M

Medical Center: _____

Social Worker Contact: _____ Social Worker E-mail: _____

Social Worker phone number: _____

We are aware that your journey is extremely difficult, and we want you to know we care. Our care team exists to listen, encourage and pray for you during your crisis.

Would you like a member of our Care Team to contact you? (Yes/No)

If Yes, please complete the following questions:

Would you prefer our Care Team to contact you by phone or email? _____

What is the best time to call? _____

Are you receiving any support from your church or a local support group? _____

Do you have family close by or actively helping you? _____

If you have other children, what are their ages? _____

On a separate piece of paper, please describe the medical testing and treatment sought since the diagnosis, including the names and locations of all health care providers consulted and the approximate dates of such testing and treatment.

FINANCIAL INFORMATION AND REQUEST FOR GRANT

1. Monthly household income before date of diagnosis: \$ _____

2. Monthly household after date of diagnosis: \$ _____

3. Please summarize the specific reason the assistance is needed and how this need is related to the child's medical condition: _____

4. **To supplement your summary above, please attach a separate sheet with a narrative detailing your child's medical condition and the strain it has put on your family, both emotionally and financially.**

5. Please list the specific expenses and amounts of your request in the table below. Attach proof of the expense (for example, a bill, receipt, or credit card statement). All payments are subject to Foundation approval and availability of funds. If more room is needed, please attach a separate sheet.

Vendor name, address, and your account number (if applicable)	Date of expense	Amount Requested	Proof of expense

SIGNATURE OF APPLICANT: I, _____ certify the above information to be true and correct. I understand that incomplete applications will be returned without action.

Signed: _____ Date: _____

All information is kept strictly confidential. Emergencies are handled as quickly as possible on a case-by-case basis. Applicants will be notified upon decision of the financial grant. Timeliness of payment will be determined by the amount of funds available at the time of application.