

# AUBREY ROSE FOUNDATION GRANT APPLICATION

## GUIDELINES

*The Aubrey Rose Foundation grant is for families with children who have a life-threatening medical condition.*

These grants are awarded on a quarterly basis. The Foundation's Board of Trustees meet in March, June, September and December however you may submit your application at any time during the year. Applicants will be notified no later than 60 days after the Board of Trustees' meeting.

Grants are awarded based on need for a child who has a life threatening medical condition. If a family has outstanding medical bills that insurance will not cover, our Foundation can possibly help out a family in need until our annual funds have been exhausted. As our funds grow, so will the number and the amount of help we will be able to give. Ineligible requests such as requests for funds to be made payable to you are not allowed; medical bills that have already been paid, submitting for food, clothing, laundry fees and anything deemed non-medical for your child will not be acceptable criteria to submit a grant request. If our Foundation finds you eligible to have a medical expense paid for, for your records, we will send a letter to you confirming what funds were provided to which provider on your behalf.

*Please fill out form completely and legibly*

**TODAY'S DATE:** \_\_\_\_\_ **PERSON FILLING OUT APPLICATION:** \_\_\_\_\_

**CHILD'S FULL NAME:** \_\_\_\_\_ **D-O-B** \_\_\_\_\_

**MOTHERS FULL NAME:** \_\_\_\_\_

**FATHERS FULL NAME:** \_\_\_\_\_

**DOES FAMILY LIVE AT SAME ADDRESS?**  YES  NO (If no, please provide addresses,

telephone #'s and email addresses for both parents when replying to question #2 below.)

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**TELEPHONE: (Home) (\_\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_\_) \_\_\_\_\_**

**E-MAIL ADDRESS:** \_\_\_\_\_

(Please attach a separate sheet of paper for your answers. Address each question asked, specifically and completely.)

- 1) Please tell us in a concise manner about your sick child and his/her condition and prognosis.
- 2) Please tell us about your immediate family. Please provide mothers full name, father's full name with first and last names and ages of children in family. If parents live in separate homes, please state full information for both.
- 3) Please attach the explanation of benefits from your insurance carrier and also, attach the coordination of benefits statement from your secondary insurance, if applicable. Also attach any bills you would like to have paid. Copies of bills are acceptable as long as they are legible.
- 4) Explain what other related bills that you have because of your child being sick (for example, Ronald McDonald House expenses for out of town medical treatment).
- 5) Explain what you would like to have paid and who that payment should be made payable to. **Please provide an itemized page with the name of the organization to be paid, their telephone # with area code, account # of claim, date of service and amount to be paid. Bills will not be paid for without this itemized statement.**
- 6) Please print this statement and then sign your name to give the Aubrey Rose Foundation permission to talk to the organizations that you want help with. I, \_\_\_\_\_ give the Aubrey Rose Foundation permission to talk on my behalf regarding my child \_\_\_\_\_. Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print and mail this completed form, requested documents and answer sheet to:

Aubrey Rose Foundation  
Grant Request  
7805 Affinity Place  
Cincinnati, OH 45231