AUBREY ROSE FOUNDATION
FINANCIAL ASSISTANCE APPLICATION

GUIDELINES

The grant application is for families with children (Age 18 and under) who have a life-threatening medical condition.

These grants are awarded on a quarterly basis. The Foundation's Board of Trustees meets quarterly, 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 and will go into a queue to be paid. 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. If our Foundation finds you eligible to have a medical expense paid for, we will send a letter to you for your records, confirming what funds were provided to which provider on your behalf. If the information is complete and we cannot help you with funds, an email will be sent to you.

☐ **Check here to say that you have reviewed the policy and procedure for submitting a financial assistance application to the Aubrey Rose Foundation. For more info, go to www.aubreyrose.org.**

Please fill out form completely and legibly - * REQUIRED FIELDS – ***no grant will be given without completed information***

***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 both addresses,**

(Telephone #'s and email addresses for both parents when replying to question #2 below.)
***ADDRESS: _____**
***CITY, STATE, & ZIP: _____**
***TELEPHONE: (Home) (_____)_____ (Work) (_____)_____**
***E-MAIL ADDRESS: _____**
***CHILD'S DIAGNOSIS:_____**
***IS THIS DIAGNOSIS A LIFE-THREATENING MEDICAL CONDITION: ☐ YES ☐ NO**

(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 the condition of patient and prognosis.
2) Please tell us about your immediate family.
3) Attach outstanding medical bills related to the applicants condition you would like to have paid. Copies of bills are acceptable as long as they are legible. – please do not send original bills. 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.. Statement is attached for you to fill out. Do not send originals of bills but rather, please send a readable copy of your bill(s).**
4) If you are approved for financial assistance from the Aubrey Rose Foundation, by signing this application, you are giving the Aubrey Rose Foundation permission to publish your story if needed.

Please print this statement and then sign your name to give the Aubrey Rose Foundation permission to talk to the organization(s) that you want help with. I, _____ give the Aubrey Rose Foundation permission to talk on my behalf regarding patient _____.

Your signature: _____ Date:_____

Please mail this completed form, itemized statement, answer sheet, copy of bills, insurance turndowns, etc. to:

Aubrey Rose Foundation/Financial Assistance Request
3862 Race Road, Cincinnati, OH 45211

ITEMIZED STATEMENT

TODAY'S DATE: _____ PARENT COMPLETING APP:_____

Please print legibly

CHILD'S FULL NAME: _____D-O-B_____

MOTHERS FULL NAME: _____

FATHERS FULL NAME: _____

IN ORDER TO HAVE YOUR BILLS PAID, ALL FIELDS BELOW ARE REQUIRED TO BE COMPLETED ON THIS ITEMIZED STATEMENT.

ORGANIZATION TO BE PAID	ORG. PHONE # W/AREA CODE	ACCOUNT #	DATE(S) OF SERVICE	AMOUNT TO BE PAID

TOTAL AMOUNT OF HELP YOU ARE REQUESTING: $