PREEMIE FAMILY ASSISTANCE SUBSEQUENT APPLICATION

(Family has previously requested and received grant funding from the Preemie Family Assistance Fund)

Family Name: _____ Today's Date: _____

Current Colorado Address (if changed): _____City / State / Zip_____

Best phone to be reached: _____

Newborn Hope provides grants in the amount of $500 to support families in the NICU and as they transition home. These grants support monthly living expenses such as rent/mortgage assistance, utilities, baby equipment, medications, support therapy services and equipment. Families can re-apply monthly (maximum grant support per family cannot exceed $2,500).

Please summarize need for subsequent grant request:_____

_____

Please update or summarize current family medical situation: _____

_____

Applicant: **I certify that I am voluntarily providing the foregoing information to Newborn Hope (NBH) as part of my application for financial assistance, and that all information is true and accurate to the best of my knowledge. I permit the hospital social worker to discuss my case with NBH representatives as needed to process this request. I agree to provide additional information as requested. I understand that all information will be kept confidential. If I am the recipient of funds designated by Newborn Hope, I agree to complete a grant report detailing how the funds were used and their impact. I agree to allow NBH to use this information to evaluate and measure program impact, and share to the community when appropriate (keeping family name and personal information private if preferred).**

Medical Referral: **I certify that in my professional opinion this request for assistance is warranted and appropriate and that all information contained herein is true and accurate to the best of my knowledge.**

****If a medical referral is not able to sign this form at time of application, Newborn Hope requests that the medical referral submit an email to director@newbornhope.org qualifying the need of the family to the best of their knowledge.**

_____

Signed by: *Applicant* **Date**

_____ _____

Signed by: *Medical Referral* **Date** **Print name of medical referral**

Medical Referral Email:_____ **Phone**_____

By applying for a grant from Newborn Hope, you are agreeing to and understand the following:
All information is kept confidential and used for funding determination only. Newborn Hope will not share personal information unless with permission of the family. The information provided is only used to understand statistical data that allow us to access new and additional funding sources. If additional information/documentation about the product or services in your funding application can benefit your request, please attach it with your application. Grant checks must be cashed within 90 days, or unless otherwise notified by grantee and agreed upon by Newborn Hope. Receipts and/or invoices will be required as deemed necessary by Newborn Hope, and grant checks will be made out to vendors when possible. Grant applications will be reviewed on an ongoing basis and determined based on funds available. Grants are provided to families residing in Colorado- must have a Colorado mailing address.

For office use only:

Previous date of grant award: _____

Previous grant supported family with (circle services that apply):

Rent / mortgage assistance Utilities Baby equipment Transportation

Other:_____