PREEMIE FAMILY ASSISTANCE FUND APPLICATION

Applicant Information

Applicant's Full Name: _____ Today's Date: _____

Address (Colorado): _____Zip_____

Home Phone: _____ Cell Phone: _____ Email: _____

Mother's Age: _____ Race (optional): _____ US Citizen?_____

Mother's Health History:

_____

_____

How many family members live in your household? _____

Birth & NICU Information

Infant(s') Last Name(s) _____ Date of Birth: _____Gestational age_____

Infant(s') First Name(s) & Gender(s): (M/F)_____(M/F)_____ (M/F) _____

Birth weight(s):_____, _____, _____ Current age of infant(s): _____

Birth Hospital: _____ Current/Discharge Hospital: _____

Expected/Date of NICU discharge: _____ Social Worker: _____

Please provide information regarding infant's birth complications, current health/special needs and anticipated special needs at time of discharge:

_____

_____

_____

_____

_____

Financial Information

Mother's employer_____FMLA/Maternity Leave benefits and end date?_____

Father's employer_____FMLA/Maternity Leave benefits and end date? _____

Public or other benefits, if any, mother and/or infant receive (please circle all that apply):

None Medicaid Private Health Ins WIC SSI Other _____

What is your current housing situation? (Please circle one.) Do you expect this to change in the next two months?_____

Rent Own Temporary Housing Other

What is your current annual income? (Please circle one.)

Less than $20,000 **$20,000 - $44,999** **$45,000 - $69,999** **$70,000 – 99,999** **$100,000+**

Other support and/or financial considerations (*family or parent support, etc.*):

_____

_____

Newborn Hope's Preemie Family Assistance Fund provides a $500 grant to a family to be used for the following purposes. Receipts need to be submitted when applicable. Families may re-apply for additional funding after 30 days of grant award date (max grant award per family is $2,500).

€ Baby Equipment (*car seat, stroller, pack & play, bouncy seat & monitor)*

€ Transportation (*to / from hospital for visitation*)

€ Emergency Living Expenses (Please include lease agreement / utilities / other bill with the application)

If applying for rent assistance, please list who check is to be made out to: _____

€ Therapies, professional counseling services, medications, adaptive equipment.

Please specify need:_____

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.

With Hope, The Newborn Hope Preemie Family Assistance Fund Team
Please mail application to the address below, or email completed application to director@newbornhope.org.