



# Give Hope Foundation

## Application Form For Emergency Assistance

### Applicant Information

Child's Name:	Date of birth:
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### Diagnosis:

Diagnosis:	Diagnosis Date:
Doctor:	Treatment Facility:
Type of Treatment:	

### Parent/Guardian Information:

First	MI	Last	SSN:	Date of Birth	Place of birth
Home Address:				City/State/Zip:	
Home Phone: (    )			E-mail Address:		How Long?
Do You <input type="checkbox"/> Own <input type="checkbox"/> Rent		Monthly Mortgage/ Rental Payment: \$ _____		Mortgagee or Landlord Name:	Mortgage Account No.

### Employment Information

Current employer:					
Employer address:					How long?
City:			State/Zip:		Phone:
Type of business:					Fax:
Position:		Salary:                    (    ) Month \$                    per    (    ) Year		Supervisor's Name:	
Other Income Source:					Amount: \$

### Spouse/Significant Other (Living in same residence)

First	MI	Last	SSN:	Date of Birth	Place of birth:
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### Employment Information:

Current employer:					
Employer address:					How Long?
City:			State/Zip:		Phone:
Type of Business:					Fax:
Position:		Salary:                    (    ) Month \$                    per    (    ) Year		Supervisor's Name:	
Other Income Source:					Amount: \$

### Sibling(s) Information:

Name:	Age:
Name:	Age:
Name:	Age:

## Give Hope Foundation Application for Emergency Assistance – Continued

### Monthly Expenses:

Utilities: (Electric, Gas, Water) \$	Auto Expense (Gas Repairs, Insurance): \$	Phone: \$
Medical: \$	Medications: \$	Dental: \$
Food: \$	Clothing: \$	Eye: \$
Child Care/Elder Care: \$		Insurance \$
		Credit Cards: \$
	Other(s) (List with amounts):	

### Other Financial Assistance:

Has money been raised on behalf of the applicant? Circle one:      Yes              No
If yes, How Much and How? \$_____.
Has there been assistance from other organizations?
If yes, Organization name:
Type of assistance:

**I authorize Give Hope to share this application with other charitable organizations that may also be able to provide assistance.**

Check one:	Yes:	No:
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### Financial Assistance Requested: (Please Prioritize)


### Financial Impact

What impact has this diagnosis had on your current income or financial situation?
What other financial resources do you have access to, or are you aware of that may assist you with treatment or other related costs?

### Explanation of Emergency Situation:


### Use of Photographic Images:

The Give Hope Foundation has authorization to use photographic images of the applicant.

Check one: (Must be completed.)	Yes:	No:
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Signature of Applicant:	Date:
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### Office Use Only

Examiner:	Date:	Recommendation:
Approved by:	Date:	Assistance Allocated: