335 Heart Foundation
in loving memory of Morgan Avery

INDIVIDUAL/FAMILY FINANCIAL ASSISTANCE APPLICATION

To be completed by the parent/guardian of the child. Child must be under the age of 20 to qualify. Financial assistance depends on the amount of funds available at the time of application.

Please email completed form to ksmith@335heart.org

DATE: _____ APPLICANT NAME:_____

CHILD'S NAME:_____ CHILD DOB:_____

STREET ADDRESS: _____

CITY:_____ STATE_____ ZIP CODE_____

APPLICANT TELEPHONE:_____ ALTERNATE TELEPHONE:_____

APPLICANT EMAIL:_____

AMOUNT OF FINANCIAL ASSISTANCE REQUESTED*: _____

PLEASE INDICATE WHAT THE FUNDS WILL BE USED FOR AND PROVIDE BRIEF EXPLANATION OF REASON FOR FINANCIAL NEED:

_____

_____

_____

HAS THE FAMILY RECEIVED ANY FUNDING FROM OTHER SOURCES (such as GoFundMe or other)? ☐ Yes ☐ No

If Yes – please indicate total financial assistance received to date:_____

MEDICAL PROVIDER CONFIRMATION OF DIAGNOSIS *(to be completed by provider)*

PROVIDER NAME:_____ PROVIDER AFFILIATION: ☐ Hospital ☐ Cardiologist

CHILD DIAGNOSIS:_____

IS THE CHILD'S DIAGNOSIS A CONGENITAL HEART DEFECT? ☐ Yes ☐ No

Signature of Provider:_____ Date:_____

By signing below I certify the above information provided is true and correct according to my knowledge.

Applicant Signature: _____ Date:_____

**If funds are to be used for specific fixed costs (i.e. travel, lodging, medical bills, funeral costs) payment will be arranged directly with the provider. For assistance relating to incidentals (i.e. food, fuel or hospital parking), payment directly to the family will be made with a statement from the family of how the funds will be used.*