

THE BRITNI FOUNDATION
APPLICATION FOR FINANCIAL ASSISTANCE
(Specialized Care For Children Division)

I. Applicant Information *(Please Print Below)*

- Child's Legal Name _____ AGE _____
(Last) (First) (Middle)
- Street Address _____
- City _____
- State _____ Zip _____ County _____
- Birthdate _____ Sex: Male Female
Month/Day/ Year
- Child's Social Security # _____ - _____ - _____ Primary Language Spoken _____

Optional Information
Race: <input type="checkbox"/> Black <input type="checkbox"/> American Indian
<input type="checkbox"/> White <input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic <input type="checkbox"/> Other _____

For Office Use Only
SCC ID _____
Date Of Contact _____
Date Sent/Initials _____
Date Received _____
Date Reviewed _____
Reviewer _____

Applying Parent/Legal Guardian Name _____ Birthdate _____
(Last) (First) (MI)

Education Level _____ Age _____ Single _____ Married _____ Divorced _____ Widowed _____

Applying Parent/Legal Guardian Social Security # _____ - _____ - _____ Email _____

Street Address _____

City _____ State _____ Zip _____ County _____

Relationship to Child _____ Phone () _____

Additional Parent/Legal Guardian (if any) _____ Birthdate _____
(Last) (First) (MI)

Education Level _____ Age _____ Single _____ Married _____ Divorced _____ Widowed _____

Additional Parent/Legal Guardian Social Security # _____ - _____ - _____ Email _____

Street Address (if different from above) _____

City _____ State _____ Zip _____ County _____

Relationship to Child _____ Phone () _____

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II. General Information

Child:

	yes	no	
Is a citizen of U.S.A.	<input type="checkbox"/>	<input type="checkbox"/>	
Lives at home with parent/guardian	<input type="checkbox"/>	<input type="checkbox"/>	
Other dependents living in the home?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, how many other children? _____
Names/Ages of the other children?	_____	age _____	birthdate _____
	_____	age _____	birthdate _____
	_____	age _____	birthdate _____
	_____	age _____	birthdate _____

Applying Parent/Legal Guardian:

	yes	no
Is a citizen of U.S.A.	<input type="checkbox"/>	<input type="checkbox"/>
If not, is permanently admitted to U.S.A. (if yes, submit copy of proof)	<input type="checkbox"/>	<input type="checkbox"/>

What kind of help do you need from The Britni Foundation? (please check)

- | | |
|--|---|
| <input type="checkbox"/> Help to pay for medical services | <input type="checkbox"/> Help to determine my child's medical needs |
| <input type="checkbox"/> Help to find specialized treatment for my child | <input type="checkbox"/> Other help (support group, referral to other agencies, etc.....) |

Tell us why you need financial assistance from The Britni Foundation. (you may attach an additional sheet of paper if necessary).

What is your combined annual family income? (please include child care payments if applicable).

- | | | |
|--|--|--|
| <input type="checkbox"/> \$0-\$20,000 | <input type="checkbox"/> \$60,000-\$80,000 | <input type="checkbox"/> \$120,000-\$140,000 |
| <input type="checkbox"/> \$20,000-\$40,000 | <input type="checkbox"/> \$80,000-\$100,000 | <input type="checkbox"/> \$ 140,000+ |
| <input type="checkbox"/> \$40,000-\$60,000 | <input type="checkbox"/> \$100,000-\$120,000 | |

Does child have (please check all that apply)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Health Insurance coverage _____ | <input type="checkbox"/> SSI |
| <input type="checkbox"/> HMO membership _____ | <input type="checkbox"/> Spend-Down |
| <input type="checkbox"/> Public Aid (medicaid) | |
| <input type="checkbox"/> HMO through Public Aid (Medicaid) | |
| <input type="checkbox"/> KidCare | |

How much financial assistance do you feel that you need from The Britni Foundation?

10% _____ 20% _____ 30% _____ 40% _____ 50% _____

60% _____ 70% _____ 80% _____ 90% _____ 100% _____

How much per month can you afford to pay towards for your child's specialized medical treatment? (Be HONEST please). _____ (specify dollar amount)

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III. Health Information

Child's diagnosis _____ Other medical problems? _____

How long have you know about this diagnosis? _____

How long have you know about the other medical problems? _____

What kind of treatment has your child needed for this diagnosis up to now? *(please check all that apply)*

- | | | | |
|--|---|--|-------------------|
| <input type="checkbox"/> outpatient medical care | <input type="checkbox"/> physical therapy | <input type="checkbox"/> medicine | other(list) _____ |
| <input type="checkbox"/> hospitalization | <input type="checkbox"/> occupational therapy | <input type="checkbox"/> special diet | |
| <input type="checkbox"/> surgery | <input type="checkbox"/> speech therapy | <input type="checkbox"/> specialized equipment | |

Please list the names of the physicians and hospitals that have treated your child his/her medical condition (s):

<u>Name</u>	<u>Address</u>	<u>Treatment Period</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who do you consider to be your child's main physician? *(please print below)*

Name _____ Specialty (if any) _____

Address _____ Zip Code _____ Telephone _____

Does your child have a physician who provides treatment for minor illnesses, well child care and immunizations (Primary Care Physician)?

Yes No If yes, who?

Name _____

Address _____ Zip Code _____ Phone _____

(if not given above)

Type of Physician: *(indicate one)*

Pediatrician Family Physician Pediatric Specialist Clinic Don't Know

Are there any other agencies or organizations helping your child? Yes No If yes, please list: _____

