NOELLE'S LIGHT FAMILY RELIEF GRANT

The *Noelle's Light Family Relief Grant* provides need-based financial assistance to families receiving treatment or after-life services following a fetal or congenital condition.

Families must complete the following application with the help of a social worker from the medical facility they are receiving or recently receive care. The application will then be reviewed by our Grant Advisory Committee and, if approved, funding will be appropriated accordingly.

ELIGIBILITY

Before proceeding, please confirm that you meet the following criteria:

1. The applicant family has a clear need for financial assistance.
2. The applicant family will be able to complete the application with the verification of a licensed social worker.
3. Families that are terminating/have terminated the pregnancy for any reason are not eligible within this program.

Additionally, the *Noelle's Light Family Relief Grant* program specifically helps families that meet at least one of the following criteria:

1. Families with an unborn child being actively treated for a fetal condition
2. Families with a born child/children, under the age of 12 months old, being actively treated for a congenital condition
3. Families that have experienced a pregnancy loss, stillbirth, or infant death due a known fetal or congenital condition.

DISTRIBUTION & USE OF FUNDS

The *Noelle's Light Family Relief Grant* pays non-medical bills directly to the vendor on behalf of the family. Examples of non-medical bills include: travel costs (flights, parking, rental cars, gas, tolls), utility bills, rent, mortage payments, funeral costs, childcare.

The maximum amount of financial support available per family is $5,000.

All information provided herein will be kept confidential and will be used solely for the purpose of evaluating candidacy for the *Noelle's Light Family Relief Grant* program.

Section 1 - Applicant Information

Applicant Full Name _____

Applicant Date of Birth _____

Applicant Email Address _____

Applicant Phone Number _____

Applicant Relationship to Child _____

Please detail the child's fetal or congenital diagnosis / condition

_____

_____

_____

_____

_____

_____

Date of diagnosis: _____ Date of delivery (if applicable): _____

Date of death (if applicable): _____

Reason for applying for financial assistance:

_____

_____

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Section 2 - Parent/Guardian Information

Parent/Guardian #1

Full Name _____ DOB _____

Street Address _____

City, State, ZIP _____

Email Address _____ Phone _____

Relationship to Child: _____

Marital Status: _____

Parent/Guardian #2 (if applicable)

Full Name _____ DOB _____

Street Address _____

City, State, ZIP _____

Email Address _____ Phone _____

Relationship to Child: _____

Marital Status: _____

Section 3 - Medical Information

Please detail the child's fetal or congenital diagnosis / condition

_____

_____

_____

_____

_____

_____

Date of diagnosis: _____ Date of delivery (if applicable): _____

Date of death (if applicable): _____

Name of Hospital: _____

Name of Social Worker: _____

Contact information for Social Worker:

Email: _____ Phone number: _____

Upon submission of this application, Noelle's Light will contact the social worker for verification.

Section 4 - Household Information

Total Annual Household Income: $_____

Family Income Sources (please check all that apply)

Salary ( ) SSI ( ) Child Support ( ) Other ( )

Parent/Guardian's Employer: _____

Is Parent/Guardian on unpaid leave? Yes ( ) No ( )

Parent/Guardian's Employer: _____

Is Parent/Guardian on unpaid leave? Yes ( ) No ( )

Please list all household members here:

Name	Date of Birth	Relationship

Section 5 - Use of Funds

All approved funds **<u>are paid directly to the vendor</u>** and usually fall into the categories below.

- Medical
- Travel for medical attention
- Mortgage/rent
- Utilities
- Property taxes/homeowner's insurance
- Vehicle expenses/insurance
- Funeral

Please describe how this assistance will help your family:

_____

_____

_____

_____

_____

_____

Total grant amount requested ($ USD): $_____

Please include a copy of the bill(s)/invoice(s) to be funded, as well a W9 from the vendor where the bill is to be paid.

Section 6 - Social Worker Verification

To be completed by Social Worker named in Section 3

Name of Social Worker: _____

Title: _____

Department: _____

Hospital: _____

License Number: _____

Email: _____ Phone number: _____

Please detail the child's fetal or congenital diagnosis / condition

_____

_____

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_____

Description of how financial assistance will help the family:

_____

_____

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_____

Signature: _____ Date: _____

Section 7 – Certification

I (we) hereby confirm that all of the information provided in this application is accurate and truthful to the best of our knowledge and ability. By signing below, I also give Noelle's Light, Inc. permission to contact (i) the social worker listed in Section 6 to verify information and (ii) the vendor of the bill(s)/invoice(s) included in Section 5 to verify details and coordinate payment.

_____ _____

Signature of Parent/Guardian #1 Date

_____ _____

Signature of Parent/Guardian #2 Date

Please email the completed form to alaughlin@noelleslight.org.