AMY'S ANGELS CORPORATION

GRANT APPLICATION

Completed applications can be emailed to info@amysangels.org or mailed to
Amy's Angels, 90 Hopmeadow Street, Weatogue, CT 06089

To apply for financial aid from Amy's Angels Corporation, please complete this Grant Application and sign where indicated. If you need additional help, please call 860-919-9276.

Amy's Angels is a gross roots organization that provides comprehensive short and long term assistance to individuals and families dealing with the debilitating effects of serious illness or injury.

Date: _____ Amount Requested (Estimate) _____

Patient Information

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

City/State/Zip: _____

Home Phone: _____

Home Email: _____

U.S. Resident: Yes _____ No_____

Gender: Male _____ Female_____

Diagnosis: _____

Date of Diagnosis: _____

Physician/Service Provider: _____

Treatment Center: _____

Referral Source: _____

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Family Information

Primary Contact: Father _____ Mother _____ Guardian _____ Other _____

Primary Contact's Name: _____

Primary Contact's Home Phone/Business Phone: _____

Insurance: _____ None _____ Medicare _____ Private _____

Are prescription drugs covered? Yes _____ No _____

If yes, please describe any limits on the prescription drug coverage _____

Please describe your family's medical and financial situation. We seek to understand what financial consequences you/your family are experiencing as a result of your illness/injury and the actions being taken to regain financial stability. Please comment on expected outcome of the treatment plan. (Add additional pages as necessary):

_____

_____

_____

_____

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_____

Type of aid you are seeking: _____

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Estimated Monthly Family Expenses

Rent/Mortgage: $_____

Utilities/Phone: $_____

Childcare: $_____

Medical: $_____

Food: $_____

Transportation: $_____

Other Ongoing Expenses: $_____

Total Monthly Expenses: **$_____**

Estimated Monthly Family Income

Wages after withholdings (i.e., take-home pay): $_____

Unemployment: $_____

Disability: $_____

Public Assistance: $_____

Social Security: $_____

Other Sources (i.e. alimony, child support, etc. $_____

Total Monthly Income: **$_____**

$_____ (Net Monthly Income)

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Please include a copy of the most recent paystub from each employer for whom you and/or a member of your family is employed.

Also include a copy of your most recent Tax Return: Received: _____Yes _____No

Have you received any financial assistance from any organization since the date of diagnosis?

_____

If so, please explain_____

_____

_____

_____

Current Financial Information:

Available Cash and Savings: $_____

Investment Accounts: $_____

Retirement Accounts: $_____

Approximate Net Worth: $_____

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Signature and Acknowledgement:

I hereby certify and affirm that the contents of this Grant Application are truthful, accurate and complete to the best of my knowledge and belief.

Applicant/Parent/Guardian Signature:_____

Print Name:_____

Date:_____