Helping One Family and One Child at a Time!

APPLICATION FOR ASSISTANCE

The Laila Rose Foundation is a 501(c)(3) non-profit dedicated to facilitating access to medically related services that have the potential to significantly enhance either the clinical condition or the quality of life of the child that are not fully covered by the available health benefit plan. This support is in the form of a grant to be used for the medical services not covered or not completely covered by health benefit plans.

Send completed application to:
Laila Rose Foundation
9272 Big Horn Rd.
Remington, Va 22734

Or email to: PattyEngh1@gmail.com

If you have questions, contact us at (540) 937-3369

IMPORTANT!

Please follow these steps to be sure your form is complete before sending:

STEP 1: Complete all sections of the form (can be filled out electronically)
STEP 2: Review each section for accuracy
STEP 3: Print the completed form
STEP 4: Sign each section that is marked with the SIGN HERE icon
STEP 5: Mail completed form to the address above
or scan and email the final document to pattyengh1@gmail.com

All information provided is strictly confidential

GUIDELINES FOR APPLICANTS

A Note to Applicants

With so many needs for funding expressed by families, critical evaluation procedures are in place to assist members of the Laila Rose Foundation Board of Directors. Please know that the Application Committee carefully reviews each request submitted and personally evaluates it according to a list of criteria. Grants will be made with the specific goal of helping the parent to be able to care for their child, thereby enhancing the quality of life for the child and his/her family. Processing time for funding requests is approximately 2-3 weeks. All requests are acknowledged at the time of receipt. A phone call, e-mail, and/or letter will be sent once a decision is made by the Application Committee. Priorities for funding distribution are as follows and are in no particular order:

- Medical, dental, vision services
- Medical equipment
- Imminent housing needs
- Rehabilitation services
- Personal adaptive support services
- Psychological/ counseling/ support services
- Assistive technology
- Home modifications due to medical need
- Recreational to improve the quality of life for the child

Qualification Guidelines

- Applications will be accepted only for children under the age of 18. However, the Laila Rose Foundation may grant exception to this rule at the Foundation's sole discretion.
- Applications will be accepted without regard to race, national origin, ethnic background, sex, or religion.
- Please be as specific as possible when completing the application regarding the details of the requested funding and how it will enhance the quality of life for the child and family.
- Applications requesting partial funding will be considered.

Required Documentation

- An application to include all appropriate sections including income and insurance information.
- Copies of medical bills and any additional information that may be needed by the Application Committee when determining funding eligibility.
- A signed letter of authorization is needed from the family to contact medical facilities for verification purposes.
- Personal contact information
    - The Laila Rose Foundation does not share contact information with any other third party.
- Applicant must submit changes to application information if employment or insurance status should change during the review process.
- Information regarding children and their families is held in strict confidence with medical professionals and other support staff.

MEDICAL CRITERIA FOR APPLICANTS

Medical Criteria

The following medical criteria will be taken into consideration by the Application Committee when determining funding eligibility.

- Life threatening medical need
- Surgical procedure necessary to increase the quality of life for the child
- Child's specific medical condition and diagnosis
- The specific impact the medical condition has on the child's life
- The specific therapy, treatment and or medical services the doctor recommends
- Previous therapy, treatment and or medical services received by the child
- The result the doctor and family hopes to achieve with the therapy, treatment or medical service

FINANCIAL CRITERIA FOR APPLICANTS

Financial Criteria

All applications will be considered based on their individual merits and availability of funds. The following financial criteria will be taken into consideration by the Application Committee when determining funding eligibility.

- Funds will not be granted to individuals in families whose Adjusted Gross Income exceeds the following scale:

Your Family Size As reported on your IRS 1040	**Adjusted Gross Income** As reported on your IRS 1040
2	$50,000
3	$75,000
4	$100,000
5 or more	$125,000

- The applicant must be covered by a health benefit plan and limits for the requested service are either exceeded, or no coverage is available and or the costs are a serious burden on the family
- Other financial resources to meet the child's need are not available
- Grants will be paid in the form of a check, not cash, directly to the licensed company, facility, manufacturer, business, service provider or individual who goods or services are provided by.
- Grant recipients who are awarded funds may reapply for another grant once the current grant funds have been completely exhausted.
- If a child is found not eligible for funding by the Laila Rose Foundation Board, whenever possible every effort will be made to try to help find other ways to assist the family through the Foundation's consultant resources.

SECTION 1 - Child's General Information

Application Date: _____/_____/_____
MM DD YYYY

Child's Name: _____

Age: _____ Date of Birth: _____/_____/_____ Male ☐ Female ☐
MM DD YYYY

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___ Cell: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Physical Address:
if different from mailing address _____

_____

_____

Diagnosis/Condition: _____

Date Diagnosed: _____/_____/_____
MM DD YYYY

General Prognosis:

Please select the need/service/procedure that you are requesting a grant for:

- ☐ Medical Services
- ☐ Dental Services
- ☐ Vision Services
- ☐ Medical Equipment
- ☐ Imminent Housing Needs
- ☐ Rehabilitation Services
- ☐ Personal Adaptive Support Services
- ☐ Psychological Support Services
- ☐ Counseling Support Services
- ☐ Assistive Technology
- ☐ Home Modifications due to Medical Needs
- ☐ Recreational to Improve the Quality of Life

Please Describe the Specific Need/Service/Procedure:

SECTION 2 - Family Information

Legal Guardian #1

Name: _____

Relationship to Patient: _____

Home Address: _____

_____

Email: _____

Phone Number: ___-___-____

Legal Guardian #2 (if applicable)

Name: _____

Relationship to Patient: _____

Home Address: _____

_____

Email: _____

Phone Number: ___-___-____

List the people who live in the child's home. Include the parent/guardians.

Name (First & Last)	**Date of Birth** MM/DD/YYYY	**Relationship to Patient**

Name of Person Filling Out Application (if not parent/guardian): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ___-___-____ Cell: ___-___-____

Email: _____

Relation: _____

SECTION 3 - Medical Contacts

Primary Care Doctor

Name: _____

Address: _____

Email: _____

Phone Number: ___-___-____

Other Doctor (if applicable)

Name: _____

Address: _____

Email: _____

Phone Number: ___-___-____

Social Worker / Case Worker

Name: _____

Address: _____

Email: _____

Phone Number: ___-___-____

Care Coordinator (if applicable)

Name: _____

Address: _____

Email: _____

Phone Number: ___-___-____

If you have a letter from your child's doctor describing his/her condition, please send us a copy with this application.

Please list all hospitals used in the past 24 months:

Hospital Name	City	State

SECTION 4 - Insurance Information

Primary Insurance Company Name: _____

Company Phone: ___-___-____

Policy Holder's Name: _____

ID Number: _____

Deductible: $_____ Deductible Met: Yes ☐ No ☐ Co-Pay: $_____

Secondary Insurance Company Name: _____

Company Phone: ___-___-____

Policy Holder's Name: _____

ID Number: _____

Deductible: $_____ Deductible Met: Yes ☐ No ☐ Co-Pay: $_____

*** Please attach medical bills (those you are asking our assistance for), or any additional information that may be needed for our review.**

SECTION 5 - Other Assistance Applicant Has Applied For

If applicable list the following assistance for which you have applied, the date applied and the reason for denial:

1. Health Insurance: _____
2. Medicare/Medicaid: _____
3. Fuel Assistance: _____
4. Social Security Disability: _____
5. Aid From Town Welfare Office / Local Social Services: _____
6. Aid From Veteran's Administration: _____
7. Other: _____

SECTION 6 - Household Income

List all income, before taxes, that your family receives.

Type of Income	Name of Family Member Receiving Income	Amount Received	How Often Choose One
Employer:			None
Employer:			None
Adoption Subsidy			None
Short/Long-term Disability			None
Child Support / Alimony			None
Food / Grocery Subsidy / Supplemental Nutrition Assistance			None
Interest / Dividends			None
Money From Family Not Living in Home			None
Pension / Retirement Income			None
Rental Income			None
Social Security Disability Insurance (SSDI)			None
Supplemental Security Income (SSI)			None
Transitional Aid to Families with Disabled Children (TAFDC)			None
Emergency Aid to Elderly Disabled & Children (EAEDC)			None
Trust / Estate / Annuities			None
Unemployment			None
Veteran's Benefits			None
Workers' Comp			None
Other Income			None
TOTAL INCOME PER YEAR	$ 0.00		

I, _____ , do hereby acknowledge that the information listed in this application is true and accurate.

Print Name: _____ SIGN HERE _____

SECTION 7 - Release of Information

☐ **I do** give permission for the Laila Rose Foundation to use pictures, videos, and history related to my child,_____, to use on the Laila Rose Foundation website and written forms of communication.

☐ **I do not** give permission for the Laila Rose Foundation to use pictures, videos, and history related to my child,_____, to use on the Laila Rose Foundation website and written forms of communication.

By signing and dating this release of information, I allow the persons or agencies listed below to share and/or access specific information about my child,_____
I understand that this is a cooperative effort by agencies and/or providers involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet my needs.

Agencies or agency representatives that will be sharing information:

Name: **Patricia Engh**
Agency: **Laila Rose Foundation**

Information to be released is:

- ☐ History
- ☐ Medical Information
- ☐ Insurance coverage
- ☐ Billing
- ☐ Summary of Treatment
- ☐ Credit
- ☐ Medications
- ☐ Legal issues/concerns
- ☐ Dental
- ☐ Other_____

Information to be released for the purpose of:

_____

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire:

_____

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent.

Child's Name:_____ Date of Birth: ____/____/____
MM DD YYYY

SIGN HERE Legal Gaurdian or Responsible Party Signature: _____

Date: ____/____/____ Relationship to Child: _____
MM DD YYYY