Patches of Light, Inc.
Application for Assistance

Patches of Light, Inc. is a nonprofit organization created to assist families with children facing catastrophic health issues and financial hardship.

Please complete entire application, including the criterion/Information checklist, in its entirety.
Please print clearly for illegible applications will not be considered.

Patient Name: _____
First ***Middle*** ***Last***

Male ___ ***Female***___ ***Date of birth:*** _____

Place of birth: _____ ***Primary language:*** _____
(State and Country)

Parent/Guardian: _____
(Name)

Relationship to child: _____

Who has legal custody? ***Mother:*** ☐ ***Father:*** ☐ ***Both:*** ☐ ***Guardian:*** ☐

Permanent address: _____

Phone: _____ ***Email:*** _____

Temporary address during treatment: _____

Name of Hospital: _____

Name of Social Worker: _____

Email: _____ ***Phone:*** _____ ***Fax:*** _____

Employment:

Mother _____ Father: _____

Number of Dependents: _____ Ages: ___/___/___/___ Total in Household: ____

Is either parent on an unpaid leave of absence? Yes ☐ No ☐

If yes, what is the source of income during their absence? _____

_____

What is the child's diagnosis?

_____

New diagnosis ☐ Reoccurrence ☐ Is patient in active treatment? Yes ☐ No ☐

What type of treatment is the child undergoing? _____

_____

How has the child's illness impacted the family's finances? _____

_____

Do you have a private medical plan? Yes ☐ No ☐
(This does not affect the determination of assistance)

Does treatment require travel? Yes ☐ No ☐

Does treatment require special equipment? Yes ☐ No ☐

Web Blog (i.e. Caring Bridge, Care Pages, etc.) _____

_____

Request for assistance*:

_____

_____

Any request over $350 will require verification of a bank balance under $2,000.

☼ ***If requesting a gas card please list gas station available to you:*** _____

☼ ***If requesting a grocery card please list store available to you:*** _____

If requesting a payment for utilities, loans, mortgage, rent, etc., you must have a current copy of the bill with legible account numbers, address and balance.

Are there additional fundraisers being conducted in support of your child? ***Yes*** ☐ ***No*** ☐
(This does not affect the determination of assistance.)

If yes, please describe:

_____

_____

Have other organizations been assisting this family? ***Yes*** ☐ ***No*** ☐

If yes, please list:

_____

_____

If no please explain why?

_____

_____

If the request is for a required monthly obligation, how will this be managed next month?

_____

_____

Utilities

Please list program eligibility and/or participation (e.g. PIPP, HEAP):

_____
_____
_____
_____
_____

In addition to completing the previous page, a letter from a social worker explaining the child's diagnosis, family situation, and the assistance being requested must be submitted. Additional pertinent information may be included here as well.

*****Criterion/ Information Checklist:***

- ***Child has a critical or terminal illness and is currently being treated for said illness.***
- ***Request for assistance is an obligation/need causing detriment to the family and care of child. (Past due utility, need for food, gas, mortgage, etc.)***
- ***If the request is for a utility, rent, mortgage or other business associated bills, all information is current and a current bill/lease/etc. is included. Payments are made directly to the creditor upon verification of amount.***
- ***If the request is for a gas card or grocery card the closest merchant is listed due to availability issues. Ex: Speedway, Exxon, BP, Giant Eagle, Wal-Mart, etc.***
- ***Application MUST come from hospital staff working with the family. Families may not apply for assistance themselves.***
- ***Applicant is not requesting reimbursements, cash allowances or individual donations.***
- ***Each blank space on the application has a reply. Use 'no', 'none', or '0' as appropriate; do not leave a blank response.***
- ***A medical professional must verify all sections of the application by providing a signature and date.***
- ***A letter from the medical professional explaining the diagnosis, treatment, family situation, assistance requested, etc., is included.***
- ***Due to HIPPA regulations, and our own guidelines, direct communication will be only be held with the medical professional submitting the application.***

Please note: An application is not a guarantee of receiving assistance from Patches of Light. Funds are limited, and based on eligibility and availability. We are unable to process incomplete applications.

Important Notice Please Read:

Patches of Light, Inc. is a charitable organization dependent upon the public for support. We are not a United Way affiliate and do not receive financial support from the government. 99% of all proceeds collected go to meet the needs of the children and their families.

I have read the guidelines for assistance and declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

_____ _____

Signature of Mother/Father/Guardian ***Date***

_____ _____

Signature of Medical Professional ***Date***

You will not be discriminated against or denied assistance because of your race, religion, color, national origin, sexual orientation or creed.

All information disclosed on this form is confidential!

Please fax the completed form to: Mindy Atwood
Patches of Light, Inc.
Fax: 1-614-529-8707

Applications will be considered within 2-3 Weeks.

P. O. Box 153
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1-614-946-7544