



APPLICATION FOR NEED-BASED GRANT

ELIGIBILITY:

- Applicants must be parents or legal guardians of a child who has been diagnosed with and is undergoing testing or treatment for a serious heart-related medical problem.
- Applicants must be facing a financial hardship as a result of travel, lodging, and other expenses associated with the child's medical problem that are not covered by insurance.
- All grants are awarded at the Foundation's discretion on a first come, first served basis. The Foundation may approve an amount lower than the amount requested or deny the request completely.
- Timeliness of payment will be determined by the amount of funds available at the time of application.

APPLICATION INSTRUCTIONS: (incomplete applications will be returned without action)

- Applicants must complete this application.
- Applicants must attached copy of a recent pay stub.
- To the extent possible, applicants must attach proof of expenses incurred. Applicants who cannot pay a cost up front should attach a quote for the estimated amount of the expense. Grant checks are made payable to the vendor on behalf of the applicant and will be mailed to the applicant.
- Mail completed applications to the Erika Kate Foundation, PO Box 262, Muscatine, IA 52761.

APPLICANT'S INFORMATION (Please print)

Name: _____ Birthdate: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ E-mail: _____

Relationship to child: _____

CHILD'S INFORMATION (Please print)

Name: _____ Birthdate: _____

Illness or medical condition: _____

Year of diagnosis: _____ Gender (circle one): F M

Medical Center: _____

Social Worker Contact: _____ Email or Phone: _____

Please describe the medical testing and treatment sought since the diagnosis, including the names and locations of all health care providers consulted and the approximate dates of such testing and treatment. If more space is necessary, please attach additional sheets.

FINANCIAL INFORMATION AND REQUEST FOR GRANT

- 1. Monthly household income before date of diagnosis: \$ _____
- 2. Monthly household after date of diagnosis: \$ _____

3. Please summarize the specific reason the assistance is needed and how this need is related to the child’s medical condition:

- 4. **To supplement your summary above, please attach a separate sheet with a narrative detailing your child’s medical condition and the strain it has put on your family, both emotionally and financially.**
- 5. Please list the specific expenses and amounts of your request in the table below. Attach proof of the expense (for example, a bill, receipt, or credit card statement). All payments are subject to Foundation approval and availability of funds. If more room is needed, please attach a separate sheet.

| Vendor name, address, and your account number (if applicable) | Date of expense | Amount Requested | Proof of expense |
|---|-----------------|------------------|------------------|
| | | | |
| | | | |
| | | | |

SIGNATURE OF APPLICANT: I, _____, certify the above information to be true and correct. I understand that incomplete applications will be returned without action.

Signed: _____ Date: _____

All information is kept strictly confidential. The Foundation Board of Directors convenes as needed to review applications. Emergencies are handled as quickly as possible on a case-by-case basis. Applicants will be notified of the Board’s decision upon the final confirmation of the financial grant. Timeliness of payment will be determined by the amount of funds available at the time of application.