Goal:

Our mission is to be a financial blessing during a family's time of mourning with the loss of a child from the age of 20 weeks gestation, up to 1 year. Finances are the last thing a family needs to deal with during their time of loss and the added stress of large medical and funeral expenses compounds this issue. Our goal is to alleviate a small portion of that undue stress by blessing them with a financial gift towards the medical and/or funeral expenses of their choosing.

Eligibility:

In order to be eligible for financial assistance you must meet the following criteria:

- Suffered the loss of a child between 20 weeks gestation up to 1 year of age
- A total household income of less than $125,000.00 per year
- You must be the parent/legal guardian of the child that was lost (you do not have to be the person filling out the application)
- Assistance will be given for only those services not covered by or available through other resources
- A "need", not a "nice to have" basis will be considered for each request

Parents can apply for assistance in the following areas:

- Medical Bills
- Funeral Expenses
- Burial/Cremation Expenses

* **Payments will be made directly to the business entity and not to the individual or family requesting assistance. A copy or original bill for services rendered must accompany the Financial Assistance Application.**

How to Apply:

- Fill out a Financial Assistance Application and submit one of the following ways:
    - Email to ourchildrensblessing@gmail.com
    - Fax to (Attn: Our Children's Blessing) 806-376-4424
    - Mail or Hand Delivery:
        - The Hope & Healing Place
Attn: Our Children's Blessing
1721 S. Tyler
Amarillo, TX 79102

OUR CHILDREN'S BLESSING

Financial Assistance Application

APPLICANT INFORMATION

Applicant Name: ______________________

Spouse/Partner: ______________________

Street Address: ______________________ Apartment/Unit #: ________

City: ____________ State: ____________ Zip Code: ________

Phone: ____________ E-mail Address: ____________

Childs Name: ____________ Date of Birth: ____________ Date of Death: ____________

If stillborn, how many weeks gestation? ________ Primary Diagnosis: ____________

Briefly identify the need(s): ______________________

Form Completed by:
(If other than applicant) ______________________

Street Address: ______________________ Apartment/Unit #: ________

City: ____________ State: ____________ Zip Code: ________

Phone: ____________ E-mail Address: ____________

FINANCIAL SUPPORT

**List in order of priority (provider invoice must be attached to application)*

1. Service Provider: ______________________ Invoice Amount: $ ________

   Brief Description of Services: ______________________

2. Service Provider: ______________________ Invoice Amount: $ ________

   Brief Description of Services: ______________________

3. Service Provider: ______________________ Invoice Amount: $ ________

   Brief Description of Services: ______________________

4. Service Provider: ______________________ Invoice Amount: $ ________

   Brief Description of Services: ______________________

INCOME STATEMENT

Total Monthly Income: $ ________ + $ ________ = **$** ________

Applicant / Spouse/Partner / **Total**

ADDITIONAL INFORMATION

Have other resources been explored to meet identified needs? If yes, please identify.

How is the child's heath care paid for? (Medicare, Medicaid, private pay, etc.)

Briefly describe the applicant's situation (family size, ages of family members, employment, marital status, etc.)

Any other information you would like to include:

Please fill out the application completely. If any portion is not applicable, indicate by inserting N/A in the space provided.

Upon completion, please sign, date, and submit the application using one of the three options below:

1. Email: ourchildrensblessing@gmail.com
2. Fax: (806) 376-4424 Attn: Our Children's Blessing
3. Mail: The Hope & Healing Place
   Attn: Our Children's Blessing
   1721 S. Tyler
   Amarillo, TX 79102

Applicant Signature: ______________________ Application Date: __________