



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) 358-3661
 - Mail to
Our Children's Blessing
P.O. Box 1101
Amarillo, TX 79105



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 health 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) 358-3661 Attn: Our Children's Blessing
3. Mail: Our Children's Blessing
P.O. 1101
Amarillo, TX 79105

Applicant Signature: _____ Application Date: _____