Vivian's Victory

P.O. Box 53525
Cincinnati, Ohio 45253
513.532.9360
viviansvictory.org

Application for Financial Assistance

Dear Applicant:

Vivian's Victory is a non-profit organization dedicated to assisting families who experience a poor prenatal diagnosis or have a child with a prolonged illness. Our mission is to provide support, programs and resources to parents of children with a poor prenatal diagnosis or a prolonged illness, not only during their hospital stay but during and after their transition home. We believe no child should fight alone and no parent should choose between their child and "life".

Please complete the following application to request financial assistance for medical and/or non-medical costs related to your child's hospital stay/illness. Applications are reviewed as received. You will be contacted once your application has been reviewed. All information will remain confidential.

Application Agreement: I hereby apply for assistance to meet medical and/or non-medical expenses due to hardship related to my child's hospital stay/illness. Vivian's Victory will determine the amount and type of assistance provided. I vouch for the accuracy and truth of the information provided in this application and authorize Vivian's Victory to confirm the accuracy of all information contained herein for the processing of this application. I authorize disclosure to Vivian's Victory of any information relevant to my application as well as any information from other pertinent agencies (including insurance companies). I am aware that falsely submitted information will automatically disqualify my eligibility for assistance from this organization. I understand that Vivian's Victory assumes no financial responsibility for any medical or non-medical bills submitted for reimbursement. I further authorize my social worker to share any pertinent information with a Vivian's Victory representative regarding our child's hospitalization.

Parent/Applicant's Signature **Date**

CHILD INFORMATION

MALE FEMALE

Child's Name **Child's Gender**

Child's Date of Birth **Anticipated Date of Discharge**

Diagnosis

Hospital

Insurance

Doctor/Specialist

Social Worker **Phone Number**

PARENT INFORMATION - MOTHER

Mother's Full Name **Date of Birth**

Street Address

City **State** **Zip Code**

Rent Own Other

Number of People in Household **Type of Residence**

Home Phone **Cell Phone**

Email Address

Current Employer (If not employed, please list last employer and dates of employment.)

Contact Person **Position**

PARENT INFORMATION - FATHER

Father's Full Name **Date of Birth**

Street Address

City **State** **Zip Code**

Rent Own Other

Number of People in Household **Type of Residence**

Home Phone **Cell Phone**

Email Address

Current Employer (If not employed, please list last employer and dates of employment.)

Contact Person **Position**

TOTAL AMOUNT OF AID REQUESTED: $ _____

1. Please give a brief description of why financial assistance is needed. Please be specific and include any supporting documents, such as bank statements or billing statements, etc.

2. What are your other sources of receiving assistance, financial or otherwise (social services, friends and family, church, savings, etc) in the past 12 months?

3. How often do you visit your baby at the hospital and what is your means of transportation?

4. How did you hear about Vivian's Victory?

If you need additional space, or would like to share more of your story with us, please attach another page to your application.

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MEDIA CONSENT RELEASE

I hereby give my consent to Vivian's Victory Non-profit Organization and/or its representatives to use photographs, audio recordings, letters, information and videotape of my child or myself and to use our names, information, these images or recordings in publications, slides, video or on the internet. I understand they will be used to inform and educate families, volunteers, media and the general public about Vivian's Victory NP and its programs, services and events. I gladly give this authorization to support the efforts of Vivian's Victory NP. I understand this authorization will remain in effect until written notice is given.

*****Signing this Media Consent Release is not a Requirement to Receive Assistance*****

Child's Name **Date of Birth**

Parent/Applicant's Signature **Date**

THIS SECTION MUST BE COMPLETED BY YOUR SOCIAL WORKER

Social Worker's Name **License #**

Email Address **Contact Phone Number**

I verify the needs of this patient and his/her family during their stay at

_____ Hospital.

Social Worker Signature **Date**

***** Please return completed applications to us at: info@viviansvictory.org *****

You will receive a response within 7 days of submitting your application.