

Approval Date:  
Approved Amount:

## Golden Halo Foundation Application

### Recipient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_  
SSN: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Citizenship: \_\_\_\_\_

### Family Information

Mother's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_

Father's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_

Case Worker's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Number in family \_\_\_\_\_ Primary Caretaker of recipient \_\_\_\_\_  
Annual household income \$ \_\_\_\_\_ Type of Insurance coverage \_\_\_\_\_  
Out-of-pocket medical expenses in the last year for recipient \$ \_\_\_\_\_  
Do you receive SSI or Social Security Disability? \_\_\_\_\_

### Clinical Information

Primary physician \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Other providers \_\_\_\_\_  
Clinical diagnosis \_\_\_\_\_ Age at onset \_\_\_\_\_  
Description/history of child's illness or health condition \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of request (travel expenses, medication, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

How will this request improve the child's life? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Total amount requested from Golden Halo Foundation \$ \_\_\_\_\_

Has funding been sought from additional sources? \_\_\_\_\_

If other funding, from whom? \_\_\_\_\_ Amount \$ \_\_\_\_\_

**Equipment request**

Type of equipment \_\_\_\_\_ Cost of equipment \$ \_\_\_\_\_

Estimated life of equipment \_\_\_\_\_ Is used equipment an option? \_\_\_\_\_

Will provider participate with Golden Halo through a discount? \_\_\_\_\_

If funding is granted, who will receive the payment? Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Equipment Recipient Has/Uses \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any additional information relevant to the request \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about Golden Halo Foundation? \_\_\_\_\_

\_\_\_\_\_

For any additional information please feel free to contact us at:

Golden Halo Foundation  
PO Box 641  
Gering, NE 69341  
(308) 225-1870

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## **Application Submittal Checklist**

*Applications for the Golden Halo Foundation will be considered on a once a month basis. Applications will be voted on in our monthly board meetings for approval. If at all possible reimbursement for expenses with receipts for medical appointments is requested.*

Please use this checklist to complete the application process for the Golden Halo Foundation. All of the following items need to be submitted before an application can be considered for funding.

\_\_\_\_\_ Completed Golden Halo Foundation form

\_\_\_\_\_ Letters from physician and/or PT, OT or SLP that includes the recommendation for request and benefits of the request for the child

\_\_\_\_\_ Official receipts/invoice/estimate on procedure or equipment requested, if a discount is available, and name and address of third party who will receive payment.

\_\_\_\_\_ Evidence of the family's financial situation (most recent Federal Income Tax return). If a child is in foster care, a letter from the caseworker indicating the child's placement will be sufficient.

\_\_\_\_\_ Letter of denial from insurance or Medicaid, if applicable

\_\_\_\_\_ HIPAA Authorization form

\_\_\_\_\_ Child's photo (We like to show pictures of the children we have been able to help)

I certify that all of the information submitted and the statements that have been made are true. I understand that any misrepresentation or omission of facts may result in cancellation of my application

Signature: \_\_\_\_\_

Date: \_\_\_\_\_