

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.) _____

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) 641-1494

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: _____