



# JULIA'S WINGS

HOPE FOR APLASTIC ANEMIA

## Application for Need-Based Grant

*"Be the change you wish to see in the world" -Gandhi*

### **Eligibility:**

- Applicants must be parents or legal guardians of a child who has been diagnosed with and is undergoing testing or treatment for **aplastic anemia**.
- Applicants must be facing a financial hardship as a result of travel, lodging, and other expenses associated with the child's medical condition that is not covered by insurance.
- All applications must be completed and submitted by a hospital social worker who knows the family and the need.
- PDF submissions are preferred printed applications must be typed or very clearly printed.

### **Application instructions:**

- All correspondence, follow up or discussion of the application will occur between the Social Worker handling the case as the single point of contact and Julia's Wings Foundation.
- Limit of \$1000 per application and a total of \$1000 per family / per month for 1 month per calendar year based on need.
- Email completed application [juliaswings@gmail.com](mailto:juliaswings@gmail.com) , or mail to Julia's Wings Foundation, PO Box 581, Sherman, CT 06784 or fax application to 860-354-9860.

**Applicant's Information:** (Please be sure to follow these instructions completely. Incomplete applications will not be processed)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Siblings: \_\_\_\_\_



# JULIA'S WINGS

HOPE FOR APLASTIC ANEMIA

**Child's Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Year of Diagnosis: \_\_\_\_\_ Gender (circle one) F M

Medical Center: \_\_\_\_\_

Social Worker Contact: \_\_\_\_\_

Social Worker Email: \_\_\_\_\_

Social Worker Phone: \_\_\_\_\_

**What is being Requested:**

**Amount of request:** \_\_\_\_\_

Need assistance with:

- |   |  |
|---|--|
| <input type="checkbox"/> Travel expenses  | <input type="checkbox"/> Mortgage/rent payment |
| <input type="checkbox"/> Meal expenses    | <input type="checkbox"/> Utility payment       |
| <input type="checkbox"/> Lodging expenses | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Co-pays          |  |

**Additional Information:** *(Social Worker – please provide any additional information that will assist us in the decision making process relative to the family situation, current financial status, prognosis, etc.)*

Social Worker Signature & Date:

\_\_\_\_\_

**We would love to see who we are helping! Please submit a family photo with the names of everyone featured to [juliaswings@gmail.com](mailto:juliaswings@gmail.com).**