THE B.A.B.Y. FOUNDATION
BUILDING A BRIGHTER YEAR

GRANT APPLICATION

The B.A.B.Y. Foundation's mission is to provide financial assistance to medically under-insured families in Northern Colorado who have children with various health-related challenges. If that is you, we are here to help you! Please take some time to complete this application ***to the best of your ability*** and we will present your application to our board at our next monthly meeting.

Application Instructions

1. Submit any current medical bills pertaining to your child's medical condition that you are asking for assistance with. We will need all pages of the bill and they must show that your child was the patient in order to make payment.

   Medical bills for everyday, routine care will not be considered (such as well-child visits, ER visits for an injury/illness that don't result in hospital admission or are not related to your child's existing medical condition, any bills pertaining to mother's care during birth, etc.)

2. Medical Bill Reimbursement:

   If a medical bill has already been paid, we may reimburse you directly (under special circumstances only). No credit card, or other related bills will be paid unless directly related to the medical bills. A copy of the credit card statement will be required showing the transaction. A medical bill must also accompany the credit card statement matching the amount purchased.

3. Enclose copies of all insurance cards. **If you are covered under Medicaid your application will not be considered for help.** You must have medical insurance to qualify for a grant.

4. Please note The B.A.B.Y. Foundation only provides grants for families in Northern Colorado. Assistance is limited to Weld and Larimer Counties.

Complete applications will be reviewed at our monthly board meeting (3rd Tuesday of each month). The B.A.B.Y. Foundation Application Liaison will contact you with the status of your application within a week of the meeting. Please do not contact McKee Wellness Foundation about your application, as they will not know the status.

If your application is approved and you receive a grant, your funds will be available for use for 12 months from the date of approval. Any funds left after that year will then be forfeited. Your application will stay on file for one calendar year, and you may reapply in that year if more financial assistance is needed. However, new applications will receive priority.

If there is any missing information in your application the Application Liaison will contact you and it will be put on hold until all the information is received and the application is complete. Please use the enclosed checklist as a guide to make sure your application is complete.

Thank you for your interest and request from The B.A.B.Y. Foundation. If you should have any questions during the application process, email president@thebabyfoundation.org.

Thank You,

The B.A.B.Y. Foundation

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Application Check List

- [ ] Child Story Sheet
- [ ] Medical History Sheet
- [ ] Family Information Sheet
- [ ] Parent Worksheet
- [ ] Financial Information Sheet
- [ ] Financial Release Form Sheet
- [ ] References Sheet
- [ ] Promotional & Marketing Photograph Release
- [ ] Electronic Photos of Child (2-3)
- [ ] Copy of Medical Bills
- [ ] Copy of all Insurance Cards
- [ ] Sign & Date All Sheets
- [ ] Mail or Email Application to:

The B.A.B.Y. Foundation
PO Box 516
Eaton, CO 80615

or president@thebabyfoundation.org

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Child's Story

(Please print or type clearly)

The B.A.B.Y. Foundation is committed to our community by providing grants to medically under-insured families in Northern Colorado who have children with various health-related challenges. In order for us to fully understand and help you with your request, we would like you to provide a short summary of your circumstances. Please feel free to attach more paper if needed.

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Medical History Information

(Please print or type clearly)

Child's Name: _____
Last

_____
First

_____
Middle

_____
Date of Birth

Child's Medical Diagnosis: _____

Date Child First Seen For Condition: _____

Physician Name: _____

Address: _____

_____

Phone: _____

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Family Information

(Please print or type clearly)

Child's Name: _____
Last First Middle Initial Date of Birth

Parent/Guardian	Parent/Guardian
Last: _____	Last: _____
First: _____	First: _____
Middle: _____	Middle: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____	State: _____
Zip: _____	Zip: _____
County: _____	County: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Email: _____	Email: _____
Date of Birth: _____	Date of Birth: _____
SS#: _____	SS#: _____

Marital Status: Married_____ Single_____ Divorced_____ Widow _____

Names of Siblings Living at Home:

_____
Last First Middle Initial Date of Birth

_____
Last First Middle Initial Date of Birth

_____
Last First Middle Initial Date of Birth

_____
Last First Middle Initial Date of Birth

Parent/Guardian Signature:_____

Parent/Guardian Signature: _____

My signature certifies that the information contained in this application is true and correct. I consent to release by my health care providers my child's medical information pertaining to the patient assistance program to be used for the program authorization process. I authorize The B.A.B.Y. Foundation to use the information on this application to process the request for a grant and further authorize the use of my social security number for identification and record keeping purposes. I understand The B.A.B.Y. Foundation reserves the right at any time, without notice, to modify or discontinue this program and its eligibility criteria.

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Parent Work Information

(Please print or type clearly)

Parent/Guardian's Employment:
(Legal Guardian)

_____
Name

_____
Address

_____

_____
Length of Time at Employment

_____
Business Phone

Parent/Guardian's Employment:
(Legal Guardian)

_____
Name

_____
Address

_____

_____
Length of Time at Employment

_____
Business Phone

Insurance Information
Please attach a copy of your insurance card (front & back).

Policyholder Name _____ ID# _____ Group # _____

Insurance Company's Name _____ Phone # _____

Address_____ City _____ State _____ ZIP _____

Max. Out of Pocket/Year $_____ Child Deductible $_____ Family Deductible $_____

Office Co-Pay $_____ Specialist Co-pay $_____ER Co-Pay $_____ Urgent Care Co-Pay $_____

Plan percentage you pay (ex: 80/20) _____

Do you have dental coverage? Yes/ No (If Yes, please attach a copy of your dental card.) Id# _____

Do you have additional prescription coverage? Yes/ No (If Yes, please attach a copy of your prescription card.)

Id# _____

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Financial Information

Please share with us some information below regarding your financial situation.
We are happy to help all types of income ranges but like to have a good picture of where you stand financially in order to help the board understand your entire situation. Please print or type clearly.

Income (Net Monthly)		Expenses (Monthly)	
Parent/Guardian	$	Rent/Mortgage	$
Parent/Guardian	$	Utilities (average/month)	$
Social Security	$	Phone	$
Disability	$	Food (average/month)	$
Unemployment	$	Car Payment	$
Other (please list)	$	Gas	$
Other (please list)	$	Medical	$
Other (please list)	$	2nd Mortgage	$
		Credit Card	$
		Personal Loan	$
		Other (please list)	$
		Other (please list)	$
		Other (please list)	$
Total Net Income	**$**	**Total Expenses**	**$**

Total amount of Grant Assistance Requested: $_____

Date Requested: _____

Have you applied or received a grant from The B.A.B.Y. Foundation or any other program before:

☐ Yes ☐ No If yes, please list name and date of organization: _____

How did you hear about The B.A.B.Y. Foundation? _____

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The B.A.B.Y. Foundation Financial Release Form
(One from each office)

The B.A.B.Y. Foundation's mission is to provide assistance to medically under-insured families in Northern Colorado who have children with various health-related challenges. We are asking you for the release of financial records or bills in order for us to assist this family in their financial needs.

Child's Information:

Last Name _____ First _____ Middle Initial _____ DOB _____

FINANCIAL INFORMATION TO BE RELEASED FROM:

Hospital/Clinic/Office Name _____

Doctor Name _____

Procedure/Hospital Stay/Radiology Imagining/ Other _____ Date of Service _____

Street Address _____

City, State and Zip _____

Phone Number _____ Fax Number _____

Account Number _____

RELEASE TO:

The B.A.B.Y. Foundation
c/o The McKee Foundation
PO Box 516
Eaton, CO 80615

thebabyfoundation.org

I grant permission for your clinic/facility to release financial information to The B.A.B.Y. Foundation for the specific procedure, admission, or medical treatment as outlined above. I grant permission for a representative from The B.A.B.Y. Foundation to discuss with your clinic/facility the specific procedure, admission, or medical treatment as outlined above and the resulting charges. I release The B.A.B.Y. Foundation, its board members and volunteers, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent authorized indicated and authorized herein. I understand that I may revoke this authorization at any time.

Patient or Legally Authorized Individual Signature _____ Date _____

Printed Name of Person Signing Release _____ Relationship _____

References

(Please print or type clearly)

Please list below two (2) - three (3) references **The B.A.B.Y. Foundation** may use to discuss and support your child's medical challenge, your need for assistance, and any other questions we may have.

Name:_____

Address:_____

Contact Phone #: _____

Relationship to Person:_____

Name:_____

Address:_____

Contact Phone #: _____

Relationship to Person:_____

Name:_____

Address:_____

Contact Phone #: _____

Relationship to Person:_____

Promotional & Marketing Photograph Release

(Please print or type clearly)

The wide recognition of **The B.A.B.Y. Foundation** has created many requests for financial aid. As you know, our foundation provides an important function in our community, and our goal is to continue assisting families in the Northern Colorado area. In order for us to continue to provide funds to families in need, we need to raise money through our annual fundraisers. **The B.A.B.Y. Foundation** is asking you to include two to three photographs of your child, and also asking you to authorize **The B.A.B.Y. Foundation** to use your photographs and your child's first name only in our marketing and promotional materials for future fundraisers. Please email your photos (with application) to president@thebabyfoundation.org.

I, the undersigned, do hereby grant permission to The B.A.B.Y. Foundation to post my and/or my child's story, photo, or other item, hereinafter referred to as "Materials," I submit to and for The B.A.B.Y. Foundation's website and Facebook/Instagram account. I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said Materials, including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the Materials or any rights therein.

Parent/Guardian Signature_____ Date _____

I acknowledge that my child is under 18 years old and lacks the legal capacity to enter into binding agreements. Accordingly, I have read this Release and consent to my child's inclusion in the Materials, will not contest the rights granted in this Release, and shall assist and support you in any and all legal proceeding for affirmation of this Agreement, should you choose to have a court of law affirm this Agreement.

Child's Name: _____
Last First Middle

Parent's Name: _____
Last First Middle

Signature _____ Date _____

☐ Please mark here if you do NOT want your child's story or pictures shared on promotional material. We are happy to abide by your request.