# APPLICATION FOR FINANCIAL ASSISTANCE FROM OXFORD KIDS FOUNDATION

The Oxford Kids Foundation will consider requests for help with alternative therapies or medical treatments not covered by insurance and **located in the state of Michigan**. Most financial help will only be for a portion of the treatment, therefore it is advised that you continue fund-raising efforts along with this grant application. The grant money will only go directly to the therapy/medical center, not to an individual. If the allotted grant money is not used up for the therapy it will be returned to the Foundation.

## HOW TO APPLY:

Please complete this application form and attach a letter of support from one of your child's therapy or medical providers. **Please include a letter about your child and why he/she needs this grant.**

**Please note that we do not fund items retroactively.**

It is important to provide as much information as possible about your request so that your application can be processed without delay. **All information must be provided**. A checklist is included for your convenience. Once all materials are provided then the application may be reviewed. Your application will be treated in confidence and will usually be considered within four weeks.

## ALTERNATIVE FUNDING

Where appropriate, we require that alternative funding be explored prior to applying for this grant. For example you may find that you are entitled to a grant from your local Rotary Club, or other charitable organization.

## SAVING LIMITS

Please note that the Oxford Kid's Foundation is unable to consider requests for financial assistance from applicants with over $16,000 in savings, after any personal contribution toward the cost of the request has been taken into consideration. Additionally, we would expect applicants with over $8,000 in savings to make a contribution toward the cost of the request.

**Please read the notes on page 1 before starting to complete this form.**

## PART 1. CONTACT INFORMATION

We require that you either reside in the state of Michigan or are seeking service in the state of Michigan.

Please complete about the applicant as fully as possible.

Name of parent: _____

Address: _____

_____

_____

Telephone (home): _____ (cell): _____

Email: _____

Marital Status: _____

Name of child: _____

Child's date of birth _____

How did you hear about us? _____

**Please give the name and address of your doctor(s).**

We will not contact your doctor if you do not consent. However, by signing this form you are giving permission for the foundation to contact any primary care physician or specialist listed here.

Name: _____

Address_____

Name: _____

Address_____

Name: _____

Address_____

Do you have a spouse/partner? ☐ No ☐ Yes

Is there another adult in the household? ☐ No ☐ Yes

If yes, what is their name? _____

What is his/her occupation? _____

Is your home: ☐ Owner occupied ☐ Privately rented ☐ Staying with friend/family

How many other children are living in the home? _____

Are there any other children living in the home who have a disability? ☐ No ☐ Yes

If yes, please explain:

_____

_____

## PART 2. FINANCIAL INFORMATION

**Parents Income**

Do you or your child get one of the following benefits, please check the relevant box and sign to confirm: ☐ Child and/or Support ☐ Income-related Employment ☐ Unemployment ☐ Disability income ☐ Other: _____

**Father/Mother present or most recent occupation and employer:**

Employer name and address.

Occupation: _____

Dates of employment:_____

Employer:_____

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**Father/Mother (spouse/partner) present or most recent occupation and employer:**

Employer name and address.

Occupation: _____

Dates of employment:_____

Employer:_____

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**Please list any other occupations you and/or your spouse/partner have had in the past.**

Please give dates if possible.

You/Spouse/Partner:

_____

_____

Spouse/partner:

_____

_____

**If you, or a member of your family has been in the armed forces, please give details.**

Name: _____ Service: _____

Rank and number: _____ Period of service: _____

Relationship to you: _____ Type of discharge: _____

**Child's Disability Income: _____**

**If parent is unable to work, provide explanation:**

_____

_____

_____

## INCOME & EXPENDITURES

Please give details of your **household** income and expenditures, as this will help us to ensure you are receiving all the benefits and other income to which you may be entitled. Disability Living Allowance and Attendance Allowance will not be considered as income. Please use **monthly** figures.

| INCOME (PER MONTH) | | EXPENDITURES (PER MONTH) | |
|---|---|---|---|
| Earnings of applicant | | Mortgage/rent | |
| Earnings of spouse/partner | | Electric | |
| Child support | | Cell Phone | |
| Spousal support | | Cable/Satellite/TV | |
| Disability | | Car Loans (year/s_____) | |
| Pension | | Gas | |
| Stocks/bonds | | Student loans | |
| Investment properties | | Health Insurance | |
| Other (define) | | House/car insurance | |
| Other (define) | | Credit card payments | |
| | | Home Equity Loans | |
| | | Child care | |
| | | Food | |
| | | Dining out | |
| | | Other (define) | |
| | | Other (define) | |
| **TOTAL MONTHLY INCOME** | | **TOTAL MONTHLY EXPENSES** | |

***** Please attach a copy of your last year's tax return, check stub from each parent/partner, copy of mortgage/rent, electric, gas, cable, phone bill, etc. *****

## SAVINGS

All applicants must complete this section.

Do you have any savings, capital or investments? ☐ Yes ☐ No

If yes, please give details. If you are making a contribution from your savings, please indicate the amount remaining. We will not consider grants for applicants with over $16,000 in savings.

| TYPE OF SAVINGS/INVESTMENTS | AMOUNT |
|---|---|
| | |
| | |
| | |

Please use this space to mention anything else about your income, expenditures or savings which might be of interest in considering your request. For example, a high level of savings may require that you make a contribution toward the cost of your request if you have not already done so. If there is any additional information that we should know about your savings, please include it here.

_____

_____

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_____

## OTHER SOURCES OF FUNDING & FUNDRAISING

Please use this space to tell about other sources of funding that you have explored or for which you have applied: (For example: Pancake Breakfast, GoFund Me, Rotary Club Requests, etc.)

Include donor(s), amount of funding received, and where the funding money will be used.

## PART 3. TREATMENT REQUEST

Please explain the type of treatment therapy you are seeking?

_____

_____

_____

_____

| | |
|---|---|
| NAME OF THERAPY | |
| COST OF THERAPY | $ |
| AMOUNT REQUESTING | $ |
| PROVIDER/THERAPY NAME | |
| PROVIDER ADDRESS | |
| PROVIDER PHONE | |
| HAVE YOU HAD A CONSULTATION | ☐ No ☐ Yes With who? _____ |

Please attach a brochure or other information about the treatment.

Please attach a letter from your insurance company stating that the treatment is not covered by your insurance plan. This is necessary for us to review your request. If you cannot provide a letter please explain why.

_____

_____

_____

_____

_____

_____

## PLEASE TELL US ABOUT YOUR CHILD AND WHY THEY NEED THE THERAPY/THERAPIES.

(Attach a separate sheet if desired)

## PART 4:

The Oxford Kids Foundation and its volunteers, will keep your personal details and those of your spouse/partner in confidence. The information given on this form will be used solely for the purpose of considering your request. It may be necessary for us to contact your occupational therapist, social worker etc. as appropriate in relation to this application. If you agree below, in some cases it may be necessary for us to share some or all of this information with other funding sources, charities, trusts, benevolent funds or similar organizations in our attempts to secure additional funding for you.

**I hereby give the Oxford Kid's Foundation permission to use this information to seek funds from other organizations in relation to this application. I declare that the above information is true to the best of my knowledge.**

Signature of Applicant: _____

Date: _____

## CHECKLIST

This checklist is for your convenience to ensure all necessary information is included.

## PART 1: CONTACT INFORMATION

____ About the applicant/residency

____ Doctor

____ Household information

## PART 2: FINANCIAL INFORMATION

____ Income

____ Employer

____ Income & Expenditure worksheet

____ Attached tax return, paycheck stub, mortgage, bills, etc.

____ Savings

____ Sources of additional funding

## PART 3: TREATMENT REQUEST

____ Background on treatment

____ Therapy provider & Amount requested

____ Insurance company rejection letter

____ Letter about your child

## PART 4: SIGNATURE

____ Application signature