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. 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. ABOUT THE APPLICANT

Please complete as fully as possible.

Name: _____

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.

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. 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:_____

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

Employer name and address.

Occupation: _____

Dates of employment:_____

Employer:_____

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:

_____

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_____

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. *****

PART 3 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.

Please use this space to tell about other sources of funding that you have explored or for which you have applied:

PART 4. PLEASE EXPLAIN CLEARLY WHAT TREATMENT YOU ARE REQUESTING A GRANT FOR AND HOW MUCH MONEY YOU ARE REQUESTING FOR THIS TREATMENT.

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Please attach a letter from your insurance company stating that the treatment is not covered by your insurance plan.

PART 5: PLEASE TELL US ABOUT YOUR CHILD AND WHY THEY NEED THE THERAPY. (ATTACH A SEPARATE SHEET IF DESIRED)

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PART 6:

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: _____