



## Blue Ryno Foundation

PO Box 1986

La Jolla, CA 92038

Phone: (866)580 0635 or (858)458-0635

Fax: (858)458-2869

Website: [www.bluerynofoundation.org](http://www.bluerynofoundation.org)

## Blue Ryno Foundation Assistance Request Form

Blue Ryno Foundation is a non-profit organization that is available to provide support resources and financial assistance to terminally or critically ill children and their families. To qualify your child must be diagnosed with a life threatening condition verified by their physician. Please complete the following application form and return to us by mail, by fax, or through your hospital social worker. You may also include a photo of your child to be used in future Blue Ryno Foundation fundraising events, brochures or other publications. Sincerely, the Board of Directors at Blue Ryno Foundation.

### ALL INFORMATION IN THIS APPLICATION IS KEPT STRICTLY CONFIDENTIAL

**Application Agreement:** I hereby apply for financial assistance to assist with the medical care needs of my child that are not covered by my insurance, or any other agency, and that I cannot otherwise arrange to finance without undue hardship as well as to assist with other financial stress as a result of my child's terminal illness. All information provided is truthful and accurate. I authorize disclosure to Blue Ryno Foundation on any information relevant to my application. I have been informed that any falsely submitted documentation or information will cause immediate discontinuation of this application process and grant award. I understand that Blue Ryno Foundation is not financially responsible for any medical or other bills submitted for reimbursement, and that financial responsibility remains to be that of the applicants. Assistance provided is at the sole discretion of the Blue Ryno Foundation. I give consent for any pictures I provide to Blue Ryno to be used in upcoming fundraising events, brochures or other publications without further permission or payment.

**Signed:**

**Parent/Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Diagnosis: \_\_\_\_\_

Child's home address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**\*Please supply copy of child's birth certificate or social security card.**

Mother: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security \_\_\_\_\_

Father: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security \_\_\_\_\_

Other Dependents Names/Ages: \_\_\_\_\_  
Type of Medical Care Required: \_\_\_\_\_  
\*Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*Hospital Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_  
Health Insurance: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Annual combined family monthly income (income/child support/SSI): \_\_\_\_\_  
Number in household = \_\_\_\_\_  
Monthly Expenses (Rent/Car/Phone/Utilities/Child Care/Credit Card- Payments/Insurance etc):  
\$ \_\_\_\_\_

**Types of assistance your family is in need of (please check all that apply):**

Emergency: Yes \_\_\_\_\_ No \_\_\_\_\_ Please indicate need:

Food \_\_\_\_\_ Transportation \_\_\_\_\_ Utilities \_\_\_\_\_ Support Resources \_\_\_\_\_ Insurance Assistance \_\_\_\_\_

Other: \_\_\_\_\_

**Please list your three most important tasks that you need assistance with?**

- 1- \_\_\_\_\_
- 2- \_\_\_\_\_
- 3- \_\_\_\_\_
- 4- \_\_\_\_\_

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**Application processing requirements checklist (please check):**

- 1 - Child's physician signature \_\_\_\_\_
- 2 - Hospital social worker signature \_\_\_\_\_
- 3 - Copy of child's birth certificate or social security card \_\_\_\_\_
- 4 - Parents contact information \_\_\_\_\_
- 5 - Parents authorization signature \_\_\_\_\_

**Hospital Documentation Section**

Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Is this a Life Threatening Illness: Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Hospital Social Worker: \_\_\_\_\_ Date \_\_\_\_\_