



Identify Child's Disabilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List Medical Equipment Associated With Disability: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How Long Has The Child Been Disabled? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does the Disability Arise From An Accident? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Child's Income: \_\_\_\_\_

SSI Income: \_\_\_\_\_ DD Income: \_\_\_\_\_

Is The Child A U.S. Citizen? \_\_\_\_\_

## **II. PARENTS' INFORMATION**

### **MOTHER**

Name of Mother: \_\_\_\_\_

Last

First

Middle

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

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer Address: \_\_\_\_\_

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

Mother's Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Mother's policy #: \_\_\_\_\_

FATHER

Name of Father: \_\_\_\_\_  
Last First Middle

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

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer Address: \_\_\_\_\_

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

Father's Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Father's Policy #: \_\_\_\_\_

Please Identify Other Children Living At Home:

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

**\*Parents' Financial Information**

\*Mother's Annual Income \_\_\_\_\_

\*Father's Annual Income \_\_\_\_\_

Do You Own Your Home? \_\_\_\_\_ Value \$ \_\_\_\_\_

List Monthly Rent or Mortgage: \_\_\_\_\_

\_\_\_\_\_

Child Support? Alimony? If so, how much? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your family receiving governmental assistance? (For example food stamps, etc.) If so, please describe in detail what assistance you are receiving. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Comments on Parents' Financial Information:

\_\_\_\_\_

Additional Comments on Child's Financial Information:

\_\_\_\_\_

\_\_\_\_\_

**\*NOTE:** Please attach a copy of each parent's most recent W-2 statement and copies of their respective last three pay stubs. All financial information shall remain privileged and confidential for use only by Alyssa's Angels.

**III. MEDICAL ASSESSMENT**

**To be completed by Physician Only**

**PRIVILIGED AND CONFIDENTIAL FOR USE ONLY BY ALYSSA'S ANGELS**

Name of Physician: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis of Child: \_\_\_\_\_

Is This Condition Considered Life Threatening? \_\_\_\_\_

What Treatments is the child undergoing? \_\_\_\_\_

How often is the child seen by the doctor? \_\_\_\_\_

Date child last hospitalized? \_\_\_\_\_

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What was child hospitalized for? \_\_\_\_\_

Date last seen by Physician: \_\_\_\_\_

Seen by Physician for? \_\_\_\_\_

Please list medications: \_\_\_\_\_

I certify that the following information is true to the best of my  
knowledge. \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

**IV. EQUIPMENT AND FINANCIAL REQUEST FORM**

Is Child's disability associated with equipment request? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Specify the Equipment you need: \_\_\_\_\_

Identify Equipment Supplier: \_\_\_\_\_

Address of Supplier: \_\_\_\_\_ Phone: \_\_\_\_\_

Item Model # (if known): \_\_\_\_\_

Please attach any information available ie: brochure, picture of equipment, insurance denials, and explanation of benefits: \_\_\_\_\_

Cost of equipment: \_\_\_\_\_

Cost of equipment after insurance: \_\_\_\_\_

Please submit explanation of benefits (EOB) from insurance company \_\_\_\_\_

Will this equipment benefit the child's life? \_\_\_\_\_

If yes, how? \_\_\_\_\_

Date Needed: \_\_\_\_\_

Is your request a financial one? \_\_\_\_\_

If yes, what amount is requested? \_\_\_\_\_

Date needed: \_\_\_\_\_

How will the financial assistance be used? \_\_\_\_\_

How will this financial assistance benefit the child's life? \_\_\_\_\_

**Please submit a photograph of child.**

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**VI. STATEMENT OF CONFIDENTIALITY AND LIABILITY RELEASE**  
**relating to any medical assessments provided by applicant and/or any medical**  
**equipment provided by Alyssa's Angels**

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In consideration for the receipt of any Medical Equipment that Alyssa's Angels may provide to the applicant herein, applicant agrees to release and hold harmless Alyssa's Angels Foundation their directors, officers, employees, agents, volunteers, successors and programs from any loss, liability, damage, cost or expense arising out of any claims or suits which may be brought or made which in any manner relate to the equipment provided to the applicant as a result of this application.

Alyssa's Angels has no affiliation or contractual relationship with the distributors and/or manufacturers of any medical equipment provided. As such, Alyssa's Angels makes no warranties or representations, including without limitation, any implied warranties, related to any equipment provided. Alyssa's Angels is not an agent, distributor or manufacturer of any of the equipment provided.

Alyssa's Angels agrees to keep confidential all information, records, data and files of any nature provided to it as a result of applicant's request for medical equipment except when, and if, Alyssa's Angels is required by a court of competent jurisdiction to release such information or is otherwise required by law to comply with such disclosure.

**Alyssa's Angels reserves the right to verify any and all background information provided in this application as well as the right to conduct background checks on any applicant, including, without limitation, credit and criminal history check and investigative reports.**

I hereby give permission to Alyssa's Angels to use and permit others to use the name and likeness of applicant, including but not limited to, applicant's family and other biographical information pertaining to the applicant in order to promote the charitable purpose of Alyssa's Angels in whatever manner the Board of Directors deem appropriate. Such authorization shall include but not be limited to use in Alyssa's Angels website, public awareness campaign, brochures, newsletters, pictures, advertisement, and solicitation to the public.

Please place an X on the appropriate line and initial and date:

I grant     I deny    permission for Alyssa's Angels to use a photographic image and biographical information of my child and/or family in Alyssa's Angels promotional materials.

**By signing this application, I hereby acknowledge that I understand and accept the terms and conditions of a Grant Applicant as set forth herein.**

Mother's Signature \_\_\_\_\_ Date \_\_\_\_\_

Father's Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Public:

On \_\_\_\_\_ the above named person(s) appeared before me personally with proper ID and I hereby notarize the signatures.

Notary Signature \_\_\_\_\_

Commission expires \_\_\_\_\_

**Please return the completed Grant Application and all requisite supporting documentation to the address below:**

**Alyssa's Angels  
PO Box 93  
West Long Branch, NJ 07764**

**You will be notified, in writing, of the decision of the Board of Trustees fro Alyssa's Angles with regard to your application. Thank you for your application.**