KYLIE KARE PROGRAM

Assistance Application Request Form

Instructions: Please complete the attached form and mail or email all documents to the address listed below.

APPLICANT INFORMATION

Name:____ DOB:____________
Last First M.I. Mon. / Day / Year

Address:____
Street Address Apartment/Unit #

____
City State Zip Code

Phone:____________________________ Email:____________________________

Please consider sending a photograph of your child with the application or by email to info@kyliestrong.org with name and patient date of birth.

PARENT/GUARDIAN INFORMATION

1) Name:____ DOB:____________
Last First M.I. mm / dd / yyyy

Relationship to the Patient:__________________________

Phone:__________________________ Email:___________________________

2) Name:____ DOB:____________
Last First M.I. mm / dd / yyyy

Relationship to the Patient:__________________________

Phone:__________________________ Email:___________________________

Is address the same as the Patient? ☐ YES ☐ NO

If No, please provide address:____

Marital Status of Parents/Guardians: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ OTHER____________

If Divorced, who is the Custodial Guardian of the Patient/Child?__________________________

Do Guardians speak English? ☐ YES ☐ NO If No, primary language:____________________

Number of children (please include their names and ages):

____

____

ASSISTANCE REQUESTED

Please check what type of assistance is needed at this time. If the request is to pay a bill, please include a copy of the bill to be paid.

☐ MORTGAGE ☐ RENT ☐ UTILITY PAYMENT ☐ CHILD CARE ☐ CAR EXPENSES

☐ HEALTH INSURANCE PREMIUMS/COBRA ☐ TREATMENT RELATED EXPENSES

☐ OTHER ____

Please describe how this assistance will help your family:

____

____

____

____

HOUSEHOLD INCOME

Total Annual Family Income: ____

Family Income Sources (Check all that apply):

☐ SALARY ☐ SSI ☐ CHILD SUPPORT ☐ TANF ☐ OTHER

1) Guardian's Employer (Name & Address):

   ____

   Is Parent/Guardian on Unpaid Leave? ☐ YES ☐ NO

2) Guardian's Employer (Name & Address):

   ____

   Is Parent/Guardian on Unpaid Leave? ☐ YES ☐ NO

How much has the family collected in monetary donations? ________________________________

If you have an active donation site please list the URL here:__________________________________

MEDICAL INFORMATION

Referring Hospital: ____

Social Worker:____

Diagnosis:_____________________________________ If Brain Tumor, grade:_________________

Date of Diagnosis:________________________________ # of relapses:_____________________

Date(s) of Relapse (mm/dd/yyyy): ____

INSURANCE INFORMATION

Does Patient have Health Insurance? ☐ YES ☐ NO

If Yes, please indicate what type of insurance (check all that apply):

☐ PRIVATE ☐ MEDICAID ☐ MEDICARE ☐ OTHER

FUNDING PROCEDURES

A team member of the Kylie Rowand Foundation will contact you by phone or email once the application has been received and processed to determine if you qualify and have been selected for a grant. Assistance is based on eligibility of funds. You may apply for assistance annually. To reapply, you will need to resubmit an application to verify that you meet eligibility requirements. Thank you.

Note: Applications will not be reviewed until all documents are completed and have been received by our organization.

You may submit your completed application via Mail or Email

Mail

2710 Alpine Blvd. PMB #128, Alpine, CA 91901

Email

info@kyliestrong.org

For more information about the Kylie Rowand Foundation, please visit our website

www.kyliestrong.org