Cardiac Kids Foundation of Florida
Financial Assistance Application

Date: _____ Applicant/Patient Name: _____ Age: _____

Patient's Medical Condition: _____

_____

Parent or Guardian Names: _____ Relationship: _____

_____ _____

Permanent Address: _____

Permanent Phone Number: (____) _____ Cell Phone: (____) _____

Email address: _____

Local Address: _____

Parent's or Guardian's Employment Status

Parent or Guardian #1: _____ Monthly Income after taxes: $_____

Position Held: _____ Dates of Employment: _____

Parent or Guardian #2: _____ Monthly Income after taxes: $_____

Position Held: _____ Dates of Employment: _____

Doctors name (Cardio): _____ Phone Number: _____

Hospital of Procedure: _____

Social Worker Contact Info at Hospital (that you give us permission to speak to about your childs case):

_____

Number of dependents supported (include spouse or other family members under the family's direct care):

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Statement of Need: Please provide a brief summary of any other variables or circumstances that you would like to be considered in this evaluation process:

_____

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_____

Signature: _____ Date: _____

Patient/Application Name: _____

Date: _____

List all debt:

Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	

Estimated out of pocket expenses associated with required medical care for the next 12 months. Please itemize to the best of your ability:

Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	

Estimate out of pocket non-medical expenses associated with the required medical care for the 12 months such as accommodations, travel, unemployment or required unpaid leave, etc. *Please itemize to the best of your ability (do not include any ordinary monthly expenses listed under family debt obligations).*

Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	
Institute:		Institute:	
Total Debt:	$	Total Debt:	$
Monthly Payment:		Monthly Payment:	

Each completed application is valid for one year. Applicants must resubmit a completed application annually to reflect any changes in the data obtained. Applicants may, however, submit a new application as often as needed throughout any year to accurately reflect a greater need which may have arisen.

This organization has limited funds and grants/assistance awards are made based on many factors, including subjective criteria determined by the board in its sole discretion and submitting an application does not guarantee receipt of any funds.