THE Isaiah Alonso FOUNDATION

WWW.ISAIAHALONSOFOUNDATION.ORG ®

*One of the objectives of The Isaiah Alonso Foundation is to financially assist deserving families of oncology patients. The Foundation provides grants to minimize the financial hardship that is directly attributable to the child's illness.*

**APPLICATION FOR FINANCIAL ASSISTANCE**

(to be completed by child's parent/legal guardian – PLEASE PRINT)

Child's Name: _____

SSN: _____ DOB: _____ Gender: _____

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell phone: _____

E-mail Address: _____

Total Annual Household Income: (explain on page 2)_____

Requested grant amount: _____

How do you intend to use the requested grant: _____

_____

_____

_____

_____ _____

*Parent/Legal Guardian Date

- *By signing this application, you are agreeing to allow publication of your child's name and medical condition by The Isaiah Alonso Foundation. Additionally, by signing this, you are giving your medical professionals and the IAF permission to share medical information about your child's case. Finally, by signing this, you are consenting to allow the IAF to share your application with other organizations in an effort to, potentially, gain additional funds for you.*



90 Rembrandt Drive Elizabethtown, KY 42701 (270) 300-5329
www.isaiahalonsofoundation.org email: cheryl@isaiahalonsofoundation.org

**Vehicles**

Model _____ Make_____ Yr._____

Model _____ Make_____ Yr._____

Model _____ Make_____ Yr._____

List all forms of income and assistance currently receiving i.e. Income from employment, Social Security, Child Support, Disability, Pension etc

_____ amount_____

_____ amount_____

_____ amount_____

_____ amount_____

_____ amount_____

_____ amount_____

List all other Organizations or Foundations and the amount that you have applied for and received aid from.

_____ amount_____

_____ amount_____

_____ amount_____

_____ amount_____

Have you applied for aid previously from the I.A.F ____Yes_____No

Have you received aid previously from the I.A.F ____Yes_____No

How much did you receive? _____

How did you hear about IAF? _____

Please include a photo of your child along with your child's story for us to share with our supporters and donors on our webpage www.isaiahalonsofoundation.org (can be mailed with the application or e-mailed to Cheryl@isaiahalonsofoundation.org) application will not be considered until we have all the requested information.



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# MEDICAL INFORMATION

(to be completed by medical professional)

Child's Diagnosis: _____

Date of Diagnosis:_____

Child's Physician: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Please describe the child's medical condition and anticipated hospital stay:

_____ _____

Name and Title (please print) Signature

_____ _____

Date Social Worker's Email Address

Incomplete applications will be returned for completion.





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