NON-MEDICAL FINANCIAL REQUEST FORM

TODAY’S DATE:

PERSON FILLING OUT APPLICATION:

CHILD’S FULL NAME: D-O-B:

MOTHERS FULL NAME:

FATHERS FULL NAME:

DOES FAMILY LIVE AT SAME ADDRESS? □YES □ NO (If no, please provide both addresses and telephone numbers.)
ADDRESS: (Including City, State and Zip)

TELEPHONE: Home: Work:

E-MAIL ADDRESS:

INSURANCE PROVIDER (if applicable):

ARE YOU RECEIVING HELP FROM OTHER ORGANIZATIONS?

YES: NO:

CHILD’S DIAGNOSIS:

HOSPITAL:

ASSISTANCE TYPE:

□ GAS – amount requesting: $

□ GROCERY – amount requesting: $

□ FORMULA

□ HOTEL – number of nights requesting:

\*\*Specialized formula will require a doctor’s prescription

\*\*Hotel reimbursement available in the event RMH is full

PREFERRED MERCHANT(S) FOR ASSISTANCE TYPE:

HARDSHIP LETTER

The information in the hardship letter will be used to determine approval.

Please tell us about the following in a concise manner.

CHILD’S FULL NAME: D-O-B:

1. The condition of patient and prognosis.
2. Your family and other support system
3. Your hardship and need for help