MICHELLE ADEY MEMORIAL FUND GRANT APPLICATION

Today's Date_____

CHILD'S NAME _____ _____

(first) (last)

DATE OF BIRTH _____

ILLNESS _____

WHEN DIAGNOSED _____

PARENTS' NAMES MOM_____ DAD_____

(first name/maiden name/last name) (first last)

PARENTS' MAILING ADDRESS AND PHONE NUMBER

_____

_____

PARENTS' PLACE OF EMPLOYMENT

MOM:_____

DAD: _____

ARE THERE OTHER SIBLINGS? / DEPENDENTS? / AGES?_____

DO YOU HAVE MEDICAL INSURANCE?

ARE THERE ANY FUNDRAISERS BEING PLANNED FOR YOURR CHILD?

CURRENT TREATMENTS/HOSPITALIZATION/ SURGERIES

WHAT ARE YOUR FINANCIAL NEEDS **DUE TO THIS ILLNES**S…… **AT THIS TIME**?

ADDITIONAL COMMENTS

REFERENCES _____PHONE NUMBER_____