Financial Assistance Application

JR Hearts' mission is to provide financial assistance to families with young children facing major medical challenges. Grants are awarded based on need. If a family has outstanding medical bills that insurance will not cover, our non-profit can possibly help out a family in need until our annual funds have been exhausted.

As our funds grow, so will the number and the amount of help we will be able to give. **We appreciate families just asking for one grant per family so that we can help as many families as possible.**

If our non-profit finds you eligible to have a medical expense paid for, we will send a letter to you for your records, confirming what funds were provided to which provider on your behalf. If the information is complete and we cannot help you with funds, an email will be sent to you.

☐ Check here to say that you have reviewed the policy and procedure for submitting a financial assistance application to JR Hearts. Please fill out form completely and legibly.

A grant will not be given without completed information.

Child Information:

Last Name _____ First Name _____

Age _____ Birth Date (MM)(DD)(YYYY) _____ Check one: ☐ Male ☐ Female

Family Information:
Guardian #1

Last Name _____ First Name _____

Occupation _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Guardian #2

Last Name _____ First Name _____

Occupation _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

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Funding Information:

Health insurance name (Private) (Medicaid) _____

Annual family income (prior year) _____

Last year's out-of-pocket medical expenses for the child $_____

Amount requested from JR Hearts $ _____

Has funding been requested from additional sources? ☐ Yes ☐ No

If yes, please list If funding has been received, from whom?_____

Amount $ _____

How did you hear about JR Hearts? ☐ Family ☐ Friend ☐ Social worker ☐ Health care professional ☐ Internet ☐ Other

Medical Information:
(Health care professionals associated with current care)

Physician's Last Name _____Physician's First Name_____

Title (DO, MD, etc.)_____

Social Worker's Last Name _____Social Worker's First Name_____

Child's clinical diagnosis_____

Age illness started or was diagnosed _____

(Please attach a separate sheet of paper for your answers. Address each question asked, specifically and completely.)

1) Please tell us in a concise manner about the condition of patient and prognosis.

2) Please tell us about your immediate family.

3) Attach outstanding medical bills related to the applicant's condition you would like to have paid. Copies of bills are acceptable as long as they are legible. Please provide an itemized page with the name of the organization to be paid, their telephone number with area code, account number of claim, date of service and amount to be paid. Bills will not be paid for without this itemized statement. Itemized Statement is attached for you to fill out. Do not send originals of bills but rather, please send a readable copy of your bill(s).

4) If you are approved for financial assistance from JR Hearts, by signing this application, you are giving JR Hearts the right to publish your story if needed. Please print this statement and then sign your name to give JR Hearts permission to talk to the organization(s) that you want help with.

I, _____ give JR Hearts permission to talk on my behalf

regarding patient _____.

Your signature: _____ Date:_____

Please mail this completed form, itemized statement, completed application, copy of bills, etc. to: JR Hearts · PO Box 589 · Oconomowoc, WI 53066