



Application for Patient and Family Assistance

Our Mission:

To enhance the lives of local pediatric patients and their families by providing assistance, improving physical spaces, educating parents and medical staffs, and raising awareness of rare pediatric cancers.

www.KylieJaneLong.org

Family Grant Program

We provide reimbursement financial assistance to families who have a critically or chronically ill child in the hospital. We recognize how important it is to be present with your child during a hospital stay. Staying with your child provides many benefits. You are able to be an active member of your child's healthcare team, you provide insight about your child that only you know, and you are the one constant person your child can rely on as an advocate and a source of comfort. We also understand there are many financial hurdles standing in the way of a family member being present at the hospital. We are here to try to alleviate those financial hurdles standing between you and your child.

We assist with expenses related to hospital stays including parking, food, and travel. We may also assist with other household expenses holding you back from being with your child including child care for siblings and household bills such as necessary utilities, rent, or home insurance. Other financial hardships you incur may be considered with a detailed explanation of what the expense is and why it is needed. We reimburse families for these expenses, so please include copies of receipts, statements, etc. . . with your application. Please allow 30 days for processing of your application.

The Kylie Jane Long Foundation is a charitable organization that depends on its generous donors for support and continuation. We make considerations for aid based on our limited budget. The guidelines for our policies are as follows:

You will not be denied aid because of your race, religion, color, nationality, sex, or political affiliation. All information provided to us will be used in confidence and used only in ways consistent with the reason it was provided. Applications will be reviewed on a case – by –case basis and final decisions for reimbursement amounts will be made based on factors including availability of funds at the time of request.



Application for Patient and Family Assistance

Instructions for Application:

Completely fill out application. Be sure to sign and date where indicated. Failure to provide accurate information will result in denial of request.

Be sure to include documentation such as copies of receipts or statements for all requests. Failure to include copies of these materials will delay processing. Please allow 30 days for processing of applications. Application does not ensure reimbursement. You will receive email notification when your application has been received. Email all questions to elizabeth@kyliejanelong.org or call 330-808-KJLF.

Mail all applications to:

**THE KYLIE JANE LONG FOUNDATION
P.O. BOX 645
BATH, OHIO 44210**

SECTION 1: PATIENT INFORMATION

Patient's name _____ Patient's age _____

Individual(s) requesting aid _____ relationship to patient _____

Date of request _____

Parent(s) full name(s) _____

Email addresses _____

Child's Information website (Carepage, Caringbridge, etc. . .)(optional) _____

Family mailing address(this is where we will send all communications)

Siblings names and ages _____

Other family members residing in household and their relationship to patient _____

Approximate Household Income (check appropriate box)

\$0 - \$15,000

\$15,000 - \$30,000

\$30,000 - \$45,000

\$45,000 - \$60,000

\$60,000 - \$75,000

\$75,000 & over



Application for Patient and Family Assistance

SECTION 2: HOSPITAL/DOCTOR/TREATMENT INFORMATION

Child's diagnosis _____

Hospital(s) treating child _____

Referring hospital personnel's name _____

Referring hospital personnel's phone number _____

Social Worker or Child Life name _____

Social Worker or Child Life phone number _____

SECTION 3: REQUEST INFORMATION

Note: copies of documentation are necessary for reimbursement (receipts, statements, etc. . .)

Nature of request (for example: to pay for parking, food, travel expenses; to pay for sibling child-care; to pay for necessary utilities, rent, etc. . .) _____

Total dollar amount of request _____

Please provide any additional information necessary for aid consideration _____



Application for Patient and Family Assistance

SECTION 4: SIGNATURES

All signatures MUST be present for aid consideration.

Parent(s) signature _____ Date _____
_____ Date _____

Referring hospital personnel's signature
_____ Date _____

Social Worker or Child Life Signature
_____ Date _____

Please mail this completed application and copies of all receipts and bills to

THE KYLIE JANE LONG FOUNDATION
P.O. Box 645
Bath, Ohio 44210