

Deaf and Blind Children's Fund, Inc.

Application for Financial Assistance

Date Application Submitted _____

PERSONAL INFORMATION

Person Submitting Application _____

Name of Person Needing Service _____

Age _____ Grade Level _____

School Attending _____ District _____

Nature of Child's Impairment _____

Address _____

City _____ State _____ Zip _____

email: _____

Phone(s) _____ day _____ evenings _____

PURPOSE OF REQUEST

Purpose for this request, i.e. eye glasses, hearing aids, vision testing, scholarship, special program, classroom materials etc. You may attach one additional page if needed.

RELEASE OF MEDICAL INFORMATION

I hereby give my permission for the records of the above named applicant to be released to:

Utah Schools for the Deaf and the Blind
Audiology Department
742 Harrison Blvd.
Ogden, Utah 84404

Deaf and Blind Children's Fund
PO Box 12655
Ogden, Utah 84412-2655

Signature of Parent or Guardian _____ Date _____

RELATIONSHIPS

Are you related to any person(s) who works for the Utah Schools for the Deaf and the Blind?

_____yes _____no If so, who _____

Are you related to any person(s) who is a trustee of the Deaf and Blind Children's Fund?

_____yes _____no If so, who _____

REFERRAL

Complete this section if you are applying for financial aid for eye glasses, hearing aids, vision testing, medical operation, etc.

Name of doctor, audiologist, ophthalmologist or health care professional who prescribed or diagnosed your child’s need for services: _____

Address _____

City _____ State _____ Zip _____

Name of Medical Facility _____

Phone # _____ email _____

Permission to contact this health care professional if necessary _____yes _____no

****Please attach a copy of your most recent audiogram when requesting hearing aids.**

FINANCIAL

Amount Requested from the Deaf and Blind Children’s Fund _____

Total Amount Needed _____

How much money can you contribute? _____

Do you have insurance that will help cover this expense? _____yes _____no

If so, what amount? _____ Amount Remaining _____

Do you qualify for Medicaid? _____ Have you applied for Medicaid Assistance? _____

Gross Family Income _____ Was the student born in the USA _____

Total # of Persons in Family _____ Number of children under 18 years _____

Name of Employer (For person financially responsible): _____

Address of Employer: _____

****Please attach a copy of most recent paycheck stub or a letter from employer verifying employment, including employer contact information.**

Have you applied to your School District for funding? Yes _____ No _____

What other sources for funding have you applied for?

Date	Source	Pending	Amount Received
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NEED

Please write a brief statement of why you are seeking financial assistance from the Deaf and Blind Children’s Fund i.e. lack of insurance, other medical bills, lack of financial resources, extenuating circumstances, etc. You may attach an additional page to this application if needed.

PERSONAL CONTRIBUTION

Would you be willing to volunteer or offer services to Deaf and Blind Children’s Fund. If yes, please list what services you are willing to share: (such as your talents, services through your employment, trade knowledge, etc.) _____

Return this application to: **Deaf and Blind Children’s Fund, Inc.**
P.O. Box 12655
Ogden, Utah 84412-2655

Application Deadlines: **January 1**
April 1
July 1
October 1

****Every question must be answered in order for your application to be considered. Incomplete applications will be returned to you.**