The B.A.B.Y. Foundation's mission is to provide financial assistance to medically under-insured families in Northern Colorado who have children with various health-related challenges. If that is you, we are here to help you! Please take some time to complete this application *to the best of your ability* and we will present your application to our board at our next monthly meeting.

Application Instructions

- 1. Submit any current medical bills pertaining to your child's medical condition that you are asking for assistance with. We will need all pages of the bill and they must show that your child was the patient in order to make payment.
- 2. Medical bills that do not directly relate to the child's medical condition will not be considered (such as well child visit, emergency room visit for broken bones, those not related to your child's condition, any bills pertaining to mother's care during birth, etc.).
- 3. Medical Bill Reimbursement:
 - If a medical bill has already been paid, we may reimburse you directly. No credit card, or other related bills will be paid unless directly related to the medical bills. A copy of the credit card statement will be required showing the transaction. A medical bill must also accompany the credit card statement matching the amount purchased.
- 4. Enclose copies of all insurance cards. <u>If you are covered under Medicaid your application will not be considered for help.</u> You must have medical insurance to qualify for financial assistance.
- 5. Please note The B.A.B.Y. Foundation only provides assistance for families in Northern Colorado. Assistance is limited to Weld and Larimer Counties.

Complete applications will be reviewed at our monthly board meeting (3rd Wednesday of each month). The B.A.B.Y. Foundation Application Liaison will contact you with the status of your application within a week of the meeting. Please do not contact The McKee Foundation about your application, as they will not know the status.

If your application is approved and you receive financial assistance, your funds will be available for use for 12 months from the date of approval. Any funds left after that year will then be forfeited. Your application will stay on file for one calendar year, and you may reapply in that year if more financial assistance is needed. However, new applications will receive priority.

If there is any missing information in your application the Application Liaison will contact you and it will be put on hold until all the information is received and the application is complete. Please use the enclosed checklist as a guide to make sure your application is complete.

Thank you for your interest and request from The B.A.B.Y. Foundation. If you should have any questions during the application process, email president@thebabyfoundation.org.

Thank You,

The B.A.B.Y. Foundation

Application Check List

Child Story Sheet		
Medical History Sheet		
Family Information Sheet		
Parent Worksheet		
Financial Information Sheet		
Financial Release Form Sheet		
References Sheet		
Promotional & Marketing Photograph	n Release	
Electronic Photos of Child (2-3)		
Copy of Medical Bills		
Copy of all Insurance Cards		
Sign & Date All Sheets		
Mail or Email Application to: The B.A.B.Y. Foundation c/o The McKee Foundation 1805 E. 18 th St., Ste. 9 Loveland, CO 80538	or	president@thebabyfoundation.org

Child's Story (Please print or type clearly)

The B.A.B.Y. Foundation is committed to our community by providing financial assistance to medically under-insured families in Northern Colorado who have children with various healthrelated challenges. In order for us to fully understand and help you with your request, we would like you to provide a short summary of your circumstances. Please feel free to attach more paper if needed.



Medical History Information (Please print or type clearly)

Child's Name:	Last	
	First	
	Middle	
	Date of Birth	
Child's Medica	al Diagnosis:	
Date Child Fire	st Seen For Condition:	
	ne:	
Addre	ess:	
Phone	e:	

Family Information (Please print or type clearly)

Child's Name: Last	First	Middle Initial	Date of Birth	
Parent/Guardian		Pare	nt/Guardian	
Last:		Last:		
First:		First:		
Middle:		Middle:		
Address:		Address:		
City:		City:		
State:		State:		
Zip:				
County:		County:		
Home Phone:		Home Phone:		
Cell Phone:		Cell Phone:		
Email:		Email:		
Date of Birth:		Date of Birth:		
SS#:		SS#:		
Marital Status: Married Names of Siblings Living at Home:	Single	Divorced	Widow	
Last	First	Middle Initial	Date of Birth	
Last	First	Middle Initial	Date of Birth	
Last	First	Middle Initial	Date of Birth	
Last	First	Middle Initial	Date of Birth	
Parent/Guardian Signature:				
Parent/Guardian Signature:				

My signature certifies that the information contained in this application is true and correct. I consent to release by my health care providers my signature certifies that the information contained in this application is the and correct. I consent to release by my health care provides my child's medical information pertaining to the patient assistance program to be used for the program authorization process. I authorize The B.A.B.Y. Foundation to use the information on this application to process the request for financial aid and further authorize the use of my social security number for identification and record keeping purposes. I understand The B.A.B.Y. Foundation reserves the right at any time, without notice, to modify or discontinue this program and its eligibility criteria.

Parent Work Information

(Please print or type clearly)

Parent/Guardian's Em (Legal Guardian)	nployment:					
Name						
	Address					
	Length of Time at Emplo	oyment				
	Business Phone		<u> </u>			
Parent/Guardian's Em (Legal Guardian)	nployment:					
	Name					
	Address					
	Length of Time at Emplo	oyment				
	Business Phone					
		e Information				
Please	attach a copy of you	r insurance card	(front & back).			
Policyholder Name		ID#	Group #			
Insurance Company's Nan	ne		Phone #			
Address	C	ity	State ZIP			
Max. Out of Pocket/Year \$	Child Deductil	ole \$	Family Deductible \$			
Office Co-Pay \$ Specialist Co-pay \$ ER Co-Pay \$ Urgent Care Co-Pay \$						
Plan percentage you pay (ex: 80/20)						
Do you have dental covera	age? Yes/ No (If Yes, please a	ittach a copy of your de	ntal card.) ld#			
Do you have additional pre	escription coverage? Yes/ No	(If Yes, please attach a	copy of your prescription card.)			
ld#						

Financial Information

Please share with us some information below regarding your financial situation.

We are happy to help all types of income ranges but like to have a good picture of where you stand financially in order to help the board understand your entire situation. Please print or type clearly.

Income	Expenses	
(Net Monthly)	(Monthly)	
Parent/Guardian	\$ Rent/Mortgage	\$
Parent/Guardian	\$ Utilities (average/month)	\$
Social Security	\$ Phone	\$
Disability	\$ Food (average/month)	\$
Unemployment	\$ Car Payment	\$
Other (please list)	\$ Gas	\$
Other (please list)	\$ Medical	\$
Other (please list)	\$ 2 nd Mortgage	\$
	Credit Card	\$
	Personal Loan	\$
	Other (please list)	\$
	Other (please list)	\$
	Other (please list)	\$
Total Net Income	\$ Total Expenses	\$

Total amount of Financial Aid Requested: \$
Date Requested:
Have you applied or received financial aid from The B.A.B.Y. Foundation or any other program before:
☐ Yes ☐ No If yes, please list name and date of organization:
How did you hear about The B.A.B.Y. Foundation?



The B.A.B.Y. Foundation Financial Release Form

(One from each office)

The B.A.B.Y. Foundation's mission is to provide assistance to medically under-insured families in Northern Colorado who have children with various health-related challenges. We are asking you for the release of financial records or bills in order for us to assist this family in their financial needs.

Child's Information:			
Last Name	First	Middle Initial	DOB
FINANCIAL INFORMATI	ON TO BE RELEASED FROI	M:	
Hospital/Clinic/Office Nar	ne		
Doctor Name			
Procedure/Hospital Stay/	Radiology Imagining/ Other	Date of	Service
Street Address		RELE	ASE TO:
City, State and Zip Phone Number	Fox Number	c/o The Mck 1805 E. 1 Loveland	Y. Foundation Kee Foundatior 8 th St., Ste. 9 I, CO 80538 D) 617-2575
Phone Number Fax Number thebabyfoundat			
Account Number			
procedure, admission, or media B.A.B.Y. Foundation to discuss outlined above and the resultin business associates from any I	c/facility to release financial informatical treatment as outlined above. I grass with your clinic/facility the specific programmers. I release The B.A.B.Y. For egal responsibility or liability for the drized herein. I understand that I may	nt permission for a representative rocedure, admission, or medical t undation, its board members and isclosure of the above information	e from The creatment as I volunteers, and n to the extent
Patient or Legally Authori	zed Individual Signature	_	Date
Printed Name of Person	Signing Release	F	Relationship

References

(Please print or type clearly)

Please list below two (2) - three (3) references **The B.A.B.Y. Foundation** may use to discuss and support your child's medical challenge, your need for assistance, and any other questions we may have.

Name:
Address:
Contact Phone #:
Relationship to Person:
Name:
Address:
Contact Phone #:
Relationship to Person:
Name:
Address:
Contact Phone #:
Relationship to Person:

Promotional & Marketing Photograph Release

(Please print or type clearly)

The wide recognition of **The B.A.B.Y. Foundation** has created many requests for financial aid. As you know, our foundation provides an important function in our community, and our goal is to continue assisting families in the Northern Colorado area. In order for us to continue to provide funds to families in need, we need to raise money through our annual fundraisers. **The B.A.B.Y. Foundation** is asking you to include two to three photographs of your child, and also asking you to authorize **The B.A.B.Y. Foundation** to use your photographs and your child's first name only in our marketing and promotional materials for future fundraisers. Please email your photos (with application) to president@thebabyfoundation.org.

I, the undersigned, do hereby grant permission to The B.A.B.Y. Foundation to post my and/or my child's story, photo, or other item, hereinafter referred to as "Materials," I submit to and for The B.A.B.Y. Foundation's website and Facebook account. I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said Materials, including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the Materials or any rights therein.

Parent/Guardian Signature		Date		
binding agreeme in the Materials, you in any and a	will not contest the rights gra	d this Release and co anted in this Release,	gal capacity to enter into nsent to my child's inclusion and shall assist and support nt, should you choose to have	
Child's Name: _	Last	First	 Middle	
	Luot	1 1101	imaale	
Parent's Name:	Last	First	 Middle	
			ag.e	
Signature		Da	ate	
	nark here if you do NOT war onal material. We are happy	•	•	