Louisiana Pediatric Cardiology Foundation

Date: _____

New Orleans Chapter GRANT APPLICATION FORM

This application must be filled out <u>completely</u> to be considered.

Patient's Name (FIRST) _____((MI)_____ (LAST)_____

Address _____ City _____ St _____ Zip_____

Sex: M F DOB: ____/____/____ SSN: _____-____-_____ Phone: (____) _____

If prenatal, Due Date: _____ Name of Hospital for Delivery: _____

GUARANTOR INFORMATION

Mother's Name _____

Address _____

City, State, Zip _____

Home Phone ( ) _____-_____

Work Phone ( ) _____-_____

Email: _____

Father's Name _____

Address _____

City, State, Zip _____

Home Phone ( ) _____-_____

Work Phone ( ) _____-_____

Email:_____

Primary Pediatric Cardiologist: _____ Amount Requesting: _____

Surgery/Procedure Date: _____ Check payable to _____

Patient's Cardiac Diagnosis: _____

Date of Travel: _____ Insurance, Medicaid, or both? _____

Hospital Name & City patient is traveling to: _____

Annual Household Income (circle one): Less than $50,000 $50,000-$100,000 Over $100,000

* Have you received LPCF Grant Assistance in the past? Yes or No If yes, please provide the following:

Date of Assistance _____ Amount Received _____

Please provide a brief description of the medical-related financial needs that you are requesting. View the attached FAQs to review the grant guidelines.

_____

_____

_____

_____

_____

Name of Person Completing this Application (Print): _____

Signature: _____ Relationship to Patient: _____

For LPCF use only:

Approved Not Approved Date: ____/____/____ Amount: _____

Date Received: _____/_____/_____ Date Sent for Review: _____/_____/_____

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