Approval Date:
Approved Amount:

Golden Halo Foundation Application

Recipient Information Date: ___________

Name: ____________________________________ DOB ________________
SSN: ________________ Age: ______ Sex: _____ Citizenship: __________

Family Information

Mother's Name _______________________Telephone Number _______________
Address ___________________ City ________________ State ______Zip _______
Occupation ____

Father's Name ________________________Telephone Number _______________
Address ___________________ City ________________ State ______Zip _______
Occupation ____

Case Worker's Name ___________________Telephone Number _______________
Address ___________________ City ________________ State ______Zip _______

Number in family ______Primary Caretaker of recipient ______________________
Type of Insurance coverage ______________
Do you receive SSI or Social Security Disability? ___________________________

Clinical Information
Primary physician ______________________Telephone Number _______________
Other providers ____
Clinical diagnosis ________________________________Age at onset __________
Description/history of child's illness or health condition ______________________
____
____
____
____
____

Description of request (travel expenses, medication, etc.) _____________________
____
____
____

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How will this request improve the child's life? ________________________________
____
____
____

Total amount requested from Golden Halo Foundation $________________________
Has funding been sought from additional sources? _____________________________
If other funding, from whom?_________________________Amount $_____________

****Receipts and/or invoice for equipment must be attached to application before it can be considered ******

Equipment request

Type of equipment ____________________________Cost of equipment $_________
Estimated life of equipment ______________Is used equipment an option? _______
Will provider participate with Golden Halo through a discount?_________________
If funding is granted, who will receive the payment? Name_____________________
Address __________________________City _____________State _____ Zip________

Current Equipment Recipient Has/Uses_____________________________________
____
____
____

Any additional information relevant to the request ____________________________
____
____
____
____

How did you hear about Golden Halo Foundation? _____________________________
____

For any additional information please feel free to contact us at:

Golden Halo Foundation
PO Box 641
Gering, NE 69341
(308) 225-1870

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Application Submittal Checklist

Applications for the Golden Halo Foundation will be considered on a once a month basis. Applications will be voted on in our monthly board meetings for approval. If at all possible reimbursement for expenses with receipts for medical appointments is requested.

Please use this checklist to complete the application process for the Golden Halo Foundation. All of the following items need to be submitted before an application can be considered for funding.

_____ Completed Golden Halo Foundation form

_____ Letters from physician and/or PT, OT or SLP that includes the recommendation for request and benefits of the request for the child

_______***Official receipts/invoice/estimate on procedure or equipment requested, if a discount is available, and name and address of third party who will receive payment.

_____Letter of denial from insurance or Medicaid, if applicable

_____HIPAA Authorization form

_____Child's photo (We like to show pictures of the children we have been able to help)

Applications will not be considered until receipts/invoices are attached

I certify that all of the information submitted and the statements that have been made are true. I understand that any misrepresentation or omission of facts may result in cancellation of my application

Signature: ____________________________________
Date:__________________________