# 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 150036
Ogden, Utah 84415

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 150036**
**Ogden, Utah 84415**

**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.**