Just Keep Smiling

Assisting families with Children in Medical Crisis

Assistance Request Form

Social/Case Worker _____ Contact # _____

Email Address_____ Date Requested _____

Hospital_____ Child's Name _____

Parent's Name _____ Phone number _____

Parent's address _____

Dates of Hospitalization from _____ to _____

Is child currently Hospitalized _____ Receiving outpatient care _____

Request:

_____

_____

_____

Last 4 digits of Social Security Number, required for Direct Payments_____

Diagnosis: _____

Information needed for Grant applications, does not affect request eligibility:

Employment status/Employer: Mom_____ Dad_____

Total income: Under $20,000_____ $20,000-$50,000_____ Over $50,000_____

Single or Dual income: _____

Race: Black/African American ____ White/Caucasian ____ Native Hawaiian/Other _____ Decline_____