Patches of Light, Inc.
Application for Assistance

Patches of Light, Inc. is a nonprofit organization created to assist families with children facing catastrophic health issues and financial hardship.

Please complete entire application, including the criterion/Information checklist, in its entirety.

Please print clearly for illegible applications will not be considered.

Patient Name: _____
First Middle Last

Male ___ Female___ Date of birth: _____

Place of birth: _____ ***Primary language:*** _____
(State and Country)

Parent/Guardian: _____
(Name)

Relationship to child: _____

Who has legal custody? ***Mother:*** ☐ ***Father:*** ☐ ***Both:*** ☐ ***Guardian:*** ☐

Permanent address: _____
Full and complete address including zip code are required or application will be invalid

Phone: _____ ***Email:*** _____
Full and complete phone number and email address are required or application will be invalid

Temporary address during treatment: _____
Full and complete address including zip code are required or application will be invalid

Name of Hospital: _____

Name of Social Worker: _____

Email: _____ ***Phone:*** _____ ***Fax:*** _____

Employment:

Mother _____ Father: _____

Please fill in place of employment and if not employed include a brief explanation. N/A is not acceptable

Number of Dependents: _____ Ages: ___/___/___/___ Total in Household: ____

Is either parent on an unpaid leave of absence? Yes ☐ No ☐

If yes, what is the source of income during their absence? _____

_____

What is the child's diagnosis?

_____

New diagnosis ☐ Reoccurrence ☐ Is patient in active treatment? Yes ☐ No ☐

What type of treatment is the child undergoing? _____

_____

How has the child's illness impacted the family's finances? _____

_____

Do you have a private medical plan? Yes ☐ No ☐
(This does not affect the determination of assistance)

Does treatment require travel? Yes ☐ No ☐

Does treatment require special equipment? Yes ☐ No ☐

Web Blog (i.e. Caring Bridge, Care Pages, etc.) _____

_____

Request for assistance*:

_____

_____

Any request over $350 will require verification of a bank balance under $2,000.

☼***If requesting a gas card please list gas station available to you:***

_____

☼***If requesting a grocery card please list store available to you:***

_____

**Is an email gift card acceptable? If so please clearly list email to be used.*

_____

If requesting a payment for utilities, loans, mortgage, rent, etc., you must have a current copy of the bill with legible account numbers, address and balance. If the name on the bill does not match the applicant an explanation is required.

Are there additional fundraisers being conducted in support of your child? ***Yes*** ☐ ***No*** ☐
(This does not affect the determination of assistance.)

If yes, please describe:

_____

_____

Have other organizations been assisting this family? ***Yes*** ☐ ***No*** ☐

If yes, please list:

_____

_____

Have other organizations/company support options been attempted?

_____

_____

If the request is for a required monthly obligation, how will this be managed next month?

_____

_____

Utilities

Please list program eligibility and/or participation (e.g. PIPP, HEAP):

_____
_____
_____
_____
_____

In addition to completing the previous page, a letter from a social worker explaining the child's diagnosis, family situation, and the assistance being requested must be submitted. Additional pertinent information may be included here as well.

*****Criterion/ Information Checklist:***

Application will be considered void if these criterion are not recognized

- ***Child has a critical or terminal illness and is currently being treated for said illness.***
- ***Request for assistance is an obligation/need causing detriment to the family and care of child. (Past due utility, need for food, gas, mortgage, etc.)***
- ***If the request is for a utility, rent, mortgage or other business associated bills, all information is current and a current bill/lease/etc. is included. Payments are made directly to the creditor upon verification of amount.***
- ***If the request is for a gas card or grocery card the closest merchant is listed due to availability issues. Ex: Speedway, Exxon, BP, Giant Eagle, Wal-Mart, etc.***
- ***Application MUST come from hospital staff working with the family. Families may not apply for assistance themselves.***
- ***Applicant is not requesting reimbursements, cash allowances or individual donations.***
- ***Each blank space on the application has a reply. Use 'no', 'none', or '0' as appropriate; do not leave a blank response.***
- ***A medical professional must verify all sections of the application by providing a signature and date.***
- ***A letter from the medical professional explaining the diagnosis, treatment, family situation, assistance requested, etc., is included.***
- ***Due to HIPPA regulations, and our own guidelines, direct communication will be only be held with the medical professional submitting the application.***
- ***Application MUST be legible and complete for them to be considered. All illegible and/or incomplete applications will be immediately considered null and void.***

Please note: An application is not a guarantee of receiving assistance from Patches of Light. Funds are limited, and based on eligibility and availability. We are unable to process incomplete applications.

Important Notice Please Read:

Patches of Light, Inc. is a charitable organization dependent upon the public for support. We are not a United Way affiliate and do not receive financial support from the government. 99% of all proceeds collected go to meet the needs of the children and their families.

I have read the guidelines for assistance and declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

_____ _____

Signature of Mother/Father/Guardian ***Date***

_____ _____

Signature of Medical Professional ***Date***

You will not be discriminated against or denied assistance because of your race, religion, color, national origin, sexual orientation or creed.

All information disclosed on this form is confidential!

Please fax the completed form to: Mindy Atwood
Patches of Light, Inc.
Fax: 1-614-529-8707
or
Please email the completed form to: Mindy Atwood
Patchesoflight@aol.com

Applications will be considered within 2-3 Weeks.

P. O. Box 153
Hilliard, OH 43026
Patchesoflight@aol.com
www.patchesoflight.org
1-614-946-7544

Application Cover Letter

Due to an increase in applications, as well as applications not being completed before submission the following information MUST accompany your application or it will NOT be considered. **Any application not meeting the following criteria will be discarded without further notice.** Unfortunately, due to these circumstances our time for consideration has now been extended from 7-10 days to 2-3 weeks. Hopefully, we will be able to decrease our processing time once our new system of submission is in place. **This cover letter must accompany your application. Thank you!**

Criterion/Information Needed/ Guideline Checklist

- Application is current (2023 applications can be found on the website)
- Application **MUST** come from a hospital staff member currently working with the family.
- A letter from a medical professional currently working with the family explaining the diagnosis, treatment, family situation, assistance requested, etc. must accompany the application.
- The information requested must be legible and complete.
- A complete address, including state and zip code, must be included on the application for both the family requesting assistance and the social worker. MLC if necessary
- If requesting assistance with a bill, a copy of the current bill must be included with the application, as well as confirmation that a partial payment will be accepted. Handwritten bills, past notices, etc., will NOT be accepted.
- If requesting assistance with rent/mortgage, a copy of the current bill/lease must be included with the application, as well as confirmation that a partial payment will be accepted. Handwritten leases, past due notices, etc., will NOT be accepted.
- Applicants are aware that due to HIPPA and our own guidelines we are unable to speak to them personally about their application. All correspondence must be through the medical professional submitting the application and Patches of Light. Any attempts otherwise will terminate the request.
- Confirmation of an application being received is suggested due to technical/mailing issues beyond our control.
- The criterion/Information checklist on the application must also be checked and followed.
- The application process will take 2-3 weeks beginning October 24, 2019.
- The information on the application: phone number, email, fax, are for the medical personnel's use only. Families may not use the information to make further requests on their own.

Name: _____ Title: _____

Signature: _____ Date: _____
(Medical Professional)