Piper's Promise Foundation

Application for Financial Assistance

About Piper's Promise Foundation

Piper's Promise Foundation is a nonprofit organization honoring a courageous, beautiful and joyful nine-year-old girl who braved two bone marrow transplants with grace and always a smile on her face. She passed away July 24, 2022, leaving behind an unmatched and inspiring legacy. Piper was full of love, selflessness and compassion, touching the hearts of everyone she ever met. While undergoing her transplants, Piper saw other patients, other children, going through the same process whose family wasn't able to be with them due to work and financial hardships, and she wanted to help them all. So together, with Piper, our family decided to start a foundation that will raise funds for families with a child who needs a bone marrow transplant, requiring a long hospital stay, so they can always have a companion with them through those difficult and challenging times.

Pipers's Promise Foundation Grant Guidelines

In order to be considered for the PPF financial assistance grant, patients must be a bone marrow transplant patient and be affiliated with a certified transplant center or pediatric hospital requiring an extended inpatient stay. Families with a child undergoing a bone marrow transplant will be required to submit an application and provide medical documentation of patient status, any previous grants received (grant name, and the date and amount received), and financial documentation that includes previous year's household annual income. All sections of the grant application must be completed for grant consideration. Incomplete applications will not be accepted. Applicants must be under 18 years of age.

Decisions and Evaluations

All submissions will be acknowledged via email upon receipt of application to both the applicant and social worker or patient coordinator indicated on the form. Funding for the PPF grant is limited, therefore priority for the grants will be provided to the families with children fighting life threatening illnesses requiring a bone marrow transplant, who meet the eligibility guidelines and demonstrate a need for financial assistance.

Applications that are denied may reapply if there is a change in the applicants economic status. A new application would be required.

Disbursement of Funds

Disbursement of funds to approved applicants will be sent within 4-8 weeks of the application. All funds will be sent via check from Piper's Promise Foundation, and will be made out to the individual listed on the application.

Please submit applications to PipersPromise.com once completed. Click the *Apply for Grant* Tab and follow prompts for application submission.

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Application for Financial Assistance

PPF Mailing Address

Ohio Headquaters
7737 Laurel Ave #263
Cincinnati, OH 45243

Florida Chapter
5260 78th Ave N #3017
Pinellas Park, FL 33781

Application

Please complete application entirely before submission.

Patient Information

First: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

Primary Phone: _____

Email: _____

Race/Ethnicity (optional):

- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Asian
- ☐ African American/Black
- ☐ White/Non-Hispanic
- ☐ Other - Specify: _____

Parent/Guardian Information

Parent/Guardian Name:

First: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Phone: _____

Email: _____

Additional Parent/Guardian Name (if applicable):

First: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Phone: _____

Email: _____

Patient Name: _____

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Patient Medical History

Complete Diagnosis: _____

_____

Date of Dignosis(es): _____

Date/Expected Date(s) of Inpatient Stay: _____

Hospital: _____ Hospital Phone: _____

Hospital Address: _____

Physician: _____ Physician Phone: _____

Nurse Coordinator: _____ Nurse Coordinator Phone: _____

Coordinator Email: _____

Social Worker: _____ Social Worker Phone: _____

Request for Funding

Have you received financial assistance within the past 12 months: Yes ☐ No ☐

If yes, please provide: Name of Grant: _____

Date Grant Received: _____ Amount of Grant: _____

*If more than 1 grant has been received, please attach information to this application

Annual Household Income:* $ _____ Number of Household Members: _____

Please Complete Below for Total Household Earners:

Estimated Household Monthly Revenue	
Income:	Disability:
Unemployment:	Pension:
Social Security:	Other:

Estimated Household Monthly Expenses			
Rent/Mortgage:	$	Utilities:	$
Medical Insurance:	$	Caregiver Expenses:	$
Medical Expenses:	$	Other:	$

*Additional documentation may be requested prior to grant approval

Patient Name: _____

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Request for Funding Cont.

To be completed by the Primary Caregiver:

Please provide a statement that further details the request/need for grant, including but not limited to medical, family, living and financial situations, during patients transplant and inpatient stay that we should take into consideration:

Patient Name: _____

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To be completed by Social Worker/Hospital Coordinator

Patient Name: _____

Social Worker/Hospital Coordinator Name: _____

Social Worker/Hospital Coordinator Phone: _____

Social Worker/Hospital Coordinator Email: _____

Patient Diagnosis: _____

_____

Inpatient Date: _____ Expected Inpatient Duration: _____

Is Patient Covered by Medical Insurance: Yes ☐ No ☐
If yes, state name: _____

Is Patient Covered by Secondary Insurance: Yes ☐ No ☐
If yes, state name: _____

Has Patient received and previous grants: Yes ☐ No ☐
If yes, provide grant details: _____

Please provide any additional information that will assist in the decision making process, such as current financial status, changes in caregiver's employment, family situation, prognosis, etc.

I, _____ (Social Worker/Coordinator), **DO / DO NOT** (Circle recommendation) recommend grant/financial assistance need for _____ (Patient Name).

Social Worker/Hospital Coordinator Signature: _____

Social Worker/Hospital Coordinator Printed Name: _____ Date: _____

Current Physican Name: _____

Does Current Physician Concur with Social Workers Recommendation: Yes ☐ No ☐

Physican Signature: _____

Physician Printed Name: _____ Date: _____

Patient Name: _____

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Media Release

At Piper's Promise Foundation, we are committed to raising funds to provide grants to families of children requiring bone marrow transplants in need. To help us share the impact of our work with our generous donors and at our fundraising events, we kindly ask that you provide a photo or photograph's of your patient and/or your family. *
These images allow us to show the faces and stories behind our mission, inspiring continued support as we strive to assist even more families facing bone marrow transplant journeys.

I, _____ , hereby giver permission to Piper's Promise
(Parent/Legal Guardian Name)
Foundation to use the image (photographs and/or video) I submmitted with this application, for use in Piper's Promise Foundation publications including videos, presentations, emails, brochures, newletters, and at Piper's Promise Foundations events, and to use my image in electronic versions of the same publications or on the Pipers Promise Foundations website, PipersPromise.com or other electronic forms of media.

I, _____ , hereby waive any/all rights to inspect or approve
(Parent/Legal Guardian Name)
the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive my right to royalties or other compensation that arises from or is related to the use of the image('s).

Please check the box below and complete media release form.

☐ I am the parent or legal guardian of the child and patient named below. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release in its entirety. I understand that I am free to address any questions regarding this release by contacting Piper's Promise Foundation at Support@PipersPromise.com prior to signing this release, and I agree that failure to do so will be interpretted as a knowledgable and free acceptance of the terms of this release.

Name of Parent or Legal Guardian: _____

Address: _____

Signature: _____

Date: _____

* Not providing consent or signing the Media Release does not impact patient's application approval.

Patient Name: _____