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.

Piper's Promise Foundation Grant Guidelines

In order to be considered for the PPF financial assistance grant, patients must be a current bone marrow transplant patient, or be within a 6 month window prior or post transplant, 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 Apply for Grant Tab and follow prompts for application submission.

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Application for Financial Assistance

PPF Mailing Address

Ohio Headquarters

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 Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: _____

Primary Phone Number: _____

Email:

Race/ Ethnicity (optional):

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

Parent/Legal Guardian Information

Parent/ Legal Guardian Name:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ Phone: _____

Email: _____

Additional Parent/ Legal Guardian Name (if applicable):

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ Phone: _____

Email: _____

Patient Name: _____

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Patient Medical History

Complete Diagnosis: _____

Patient has/ is/ will receive a bone marrow transplant: YES ☐ NO ☐

Date of Diagnosis: _____

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

Hospital: _____ Hospital Phone: _____

Hospital Address: _____

Physician: _____ Physician Phone: _____

Nurse Coordinator: _____ Nurse Cord. Phone: _____

Coordinator Email: _____

Social Worker: _____ Social Worker Phone: _____

Request for Funding

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

If yes, please provide: Name of Grant: _____

Date Grant Received: _____ Amount of Grant: _____

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

Annual Household Income: _____ Number of Household Members: _____

Please Complete Charts 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 Continued

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 is currently/ will be/ previously received a bone marrow transplant: Yes ☐ No ☐

Patient Diagnosis: _____

_____

Inpatient Date: _____ Expected Inpatient Duration: _____

Is Patient Covered by Medical Insurance Yes ☐ No ☐

If yes, state name: _____

Is Patient Covered by Secondary Ins: Yes ☐ No ☐

If yes , State name: _____

Has Patient Received 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, _____, **DO / DO NOT** recommend grant/financial assistance for
Social Worker/Coordinator

_____.
Patient Name

Social Worker/Coordinator Signature: _____ Date: _____

Social Worker/Coordinator Printed Name: _____

Current Physician Name: _____

Does Physician agree with Social Workers Recommendation: Yes ☐ No ☐

Physician Signature: _____ Date: _____

Physician Printed Name: _____

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 give permission to
(Parent/Legal Guardian Name)

Piper's Promise Foundation to use the image (photographs and/or videos) I submitted with this application, for use in Piper's Promise Foundation's publications including videos, presentations, emails, brochures, newsletters, and at Piper's Promise Foundations events, and to use my image in electronic versions of the same publications or on the Piper's Promise Foundations website, PipersPromise.com or other electronic forms of media. I hereby waive any/all rights to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use to me is known 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 it's 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 interpreted as a knowledgeable 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: _____