Our mission is to ease the burden of families and children experiencing chronic illness and long or repeated hospital admissions by assisting with household finances, transportation costs, or funeral expenses. We believe the easiest way to be brave is fighting together and our mission is to help empower each family to be their own hero.

APPLICATION FOR ASSISTANCE

CHILD'S NAME _____

SSN_____ DOB _____ GENDER _____

DIAGNOSIS _____

DATE OF DIAGNOSIS _____ PHYSICIAN _____

HOSPITAL WHERE TREATMENT IS RECEIVED _____

ADDRESS OF HOSPITAL _____

ETHNICITY: (I PREFER NOT TO ANSWER THIS QUESTION ____)

AFRICAN AMERICAN _____ ASIAN/PACIFIC ISLANDER _____

CAUCASIAN ____ HISPANIC _____ NATIVE AMERICAN ____ OTHER _____

PARENT OR LEGAL GUARDIAN NAME _____

PERSON FILLING OUT THIS APPLICATION IF NOT PARENT OR LEGAL GUARDIAN

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

ANNUAL HOUSEHOLD INCOME _____

(*This information is used for internal purposes only, it will never be shared with an outside source and it does not affect your ability to qualify for our services.)

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

**BY SIGNING THIS APPLICATION YOU ARE ATTESTING THAT THIS INFORMATION IS TRUE TO THE BEST OF YOUR KNOWLEDGE. YOU GIVE THE "BE YOUR OWN HERO FOUNDATION, INC (BRAVE LIKE WYATT)" PERMISSION TO VERIFY THIS INFORMATION AND OTHER MEDICAL INFORMATION REGARDING YOUR CHILD WITH THEIR MEDICAL TEAM. FINALLY, BY SIGNING THIS YOU ARE GIVING PERMISSION FOR THE BE YOUR OWN HERO FOUNDATION TO PUBLICLY SHARE YOUR CHILD'S NAME AND DIAGNOSIS FOR THE PURPOSE OF ACQUIRING ADDITIONAL FUNDING FROM DONORS TO HELP MORE FAMILIES. WE WILL NOT SHARE IMAGES OF YOUR CHILD WITHOUT ADDITIONAL PERMISSION*

CHILD'S NAME _____

PROGRAM REQUESTED:

(PLEASE CHECK ONLY *ONE* PROGRAM YOU ARE REQUESTING AND REFER TO THE EXPLANATION OF PROGRAMS)
PLEASE NOTE THE ONLY REQUIREMENT TO QUALIFY FOR PROGRAMS IS YOUR CHILD MUST BE INPATIENT

❑ FINANCIAL ASSISTANCE FOR HOUSEHOLD BILLS UP TO $500
AMOUNT REQUESTED _____
INTENDED USE OF THIS GRANT _____
**PLEASE ATTACH A COPY OF THE BILL THAT INCLUDES WHERE WE SHOULD REMIT PAYMENT TO. WE PAY THE BILL DIRECTLY TO THE VENDOR.*

❑ TRANSPORTATION ASSISTANCE
$250 IN GAS GIFT CARDS WILL BE MAILED TO THE ADDRESS PROVIDED

❑ BEREAVEMENT BENEFIT
$500 TOWARDS FUNERAL SERVICES. PLEASE PROVIDE THE NAME OF THE FUNERAL HOME AND CONTACT NUMBER
_____

PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____ _____

BE YOUR OWN HERO FOUNDATION, INC (BRAVE LIKE WYATT)
5359 RABBIT FARM RD, LOGANVILLE, GA. 30052
A 501(C)3 FOUNDATION
WWW.BRAVELIKEWYATT.COM
EMAIL: INFO@BRAVELIKEWYATT.COM PHONE: 770-864-1355