

One Child Too Many A Brendan Kizer Foundation

One of the objectives of the One Child Too Many A Brendan Kizer Foundation is to help financially assist families of critically ill children, This Foundation will help provide grants to help pay for living expenses, travel, and or/lodging. We would like to help you be able to spend quality time with your brave boy or girl.

APPLICATION FOR FINANCIAL ASSISTANCE  
(To be completed by child's parent/legal guardian)

Childs Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Annual Household Income: \_\_\_\_\_

Requested grant amount: \_\_\_\_\_

How do you intend to use requested grant: \_\_\_\_\_  
\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

\* By signing this application, you are agreeing to allow publication Of your child's name and medical condition by One Child Too Many A Brendan Kizer Foundation. Additionally, by signing this, you are giving your medical professionals and the One Child Too Many A Brendan Kizer Foundation permission to share medical information about your child's case. Finally, by signing this, you are consenting to allow the One Child Too Many A Brendan Kizer Foundation to share your application with other organizations in an effort to, potentially, gain additional funds for you.

MEDICAL INFORMATION

(To be completed by medical professional)

Child's Diagnosis: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Name and Title (please print)

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

One Child Too Many A Brendan Kizer Foundation