# COOPER'S CAUSE FOUNDATION GRANT APPLICATION

## GUIDELINES

Cooper's Cause Foundation Grant is for families with children who have congenital heart defects.

These grants are awarded once per year on February 15th. Applications become available for submission from October 15th and are due no later than 5:00 p.m. on January 15th. Applicants will be notified no later than 30 days after the selection date. Name of grant recipients will be published by the foundation in means of validation.

Grants are awarded based on the requested material as well as need. Applications will be accepted from applicants within a 75 mile radius of Lawrence, KS and the State of Kansas with priority given to those in Lawrence and Douglas County. We will help as many families as our funds will allow. As our funds grow, so will the number and the amount of help we will be able to give. Ineligible requests such as medical bills that have already been paid, submitting for food, clothing, laundry fees and anything deemed non-medical for your child will not be acceptable criteria to submit for a grant request. The awarded funds will range depending on the number of recipients and need.

## OUR GUIDING PRINCIPLES

Cooper's Cause Foundation operates with the vision to provide financial assistance to families of congenital heart patients. The vision is to not only provide assistance but to completely meet the financial obligations after insurance for all hospital and doctor bills incurred by the family at the time of application. We wish to make a bold impact on lives one family at a time. The Foundations proceeds are dedicated to providing financial assistance to families of pediatric heart patients in who do have health insurance and do live above the states defined level of poverty, but who feel the impact of the financial burdens not covered by their private health insurance or other organizations paying on their behalf.

3300 Mesa Way Suite C
Lawrence, KS 66049
Ph. (785) 766-1410
Email: cooperscausefoundtion@gmail.com
www.cooperscause.org

# PLEASE COMPLETE THE FOLLOWING

**TODAY'S DATE:**_____
**PERSON COMPLETING THIS FORM AND RELATION TO CHILD:**_____
**CHILD'S FULL NAME:**_____
**MOTHER/LEGAL GUARDIAN FULL NAME:**_____
**FATHER/LEGAL GUARDIAN FULL NAME:**_____
**ADDRESS:**_____
**CITY:**_____ **STATE:**____ **ZIP CODE:**_____
**CONTACT NUMBER: (H)**_____ **(W)**_____ **(C)**_____
**EMAIL ADDRESS:**_____

## PLEASE ATTACH A SEPARATE SHEET OF PAPER FOR YOUR ANSWERS TO THE FOLLOWING. ADDRESS EACH QUESTION ASKED, SPECIFICALLY AND COMPLETELY.

1) Please tell us in a concise manner about your child's condition and prognosis.
2) Please tell us about your immediate family. *Please include siblings and their ages.
3) Please attach the explanation of benefits from your insurance carrier and also, attach the coordination of benefits statement from your secondary insurance, if applicable. Also, please provide information on any other funding you have received for your child's condition.
4) Please provide a copy of your most recent tax return.
5) Please explain what you would like to have paid and who that payment should be made payable to. Please provide and itemized page with the name of organization to be paid, their telephone number, account number, date of service and amount to be paid.
6) Please attach any medical bills you would like to have paid. Copies are acceptable.
7) Please explain any other related bills that you have and wish to be paid because of your child's condition. (I.e. Ronald McDonald House expenses, prescriptions or out of town treatment expenses)

*Cooper's Cause Foundation wishes to acknowledge siblings of congenital heart patients who are affected by their families' challenges. We celebrate siblings through our special portion of Cooper's Cause Foundation called Raelynn's Rock Stars, named after the original rock star, Raelynn, Cooper's big sister. To acknowledge the siblings of your patient applicant in a special way, please provide us with each of their names and pertinent information such as age, interests, dislikes, challenges, etc.

*We reserve the right to request additional information or clarification of information provided in this application. If the additional information is not received, the application will be considered incomplete and will no longer be considered for funding.

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## Please sign the statement below so that we may verify the above information.

I,_____, give Cooper's Cause Foundation access to all medical records and permission to talk to any organization I am requesting funding for in my above statement in regards to my child _____.

_____ _____

Signature Date

Subscribed and sworn to me by_____on this_____day of_____, 20_____.

_____

Notary Public

Please print and mail this form along with the other requested documents to:
Cooper's Cause Foundation
3300 Mesa Way Suite C
Lawrence, KS 66049

Or email to:
cooperscausefoundation@gmail.com

Or upload documents to our secure website by clicking here.

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