NO MORE UMBRELLAS FOUNDATION

Hardship Funds Assistance Application

PATIENT Name:_____ DOB:_____

Patient Diagnosis/Date: _____

PARENT(s) First, Last Name(s): _____

Mailing Address: _____

Phone: _____ Email:_____

May we share your story with our supporters on social media, email, etc.? **YES | NO**
We respect your privacy. Sharing your story is optional and not required for eligibility. (If you choose to share, space is provided on the second page of this application.)

*By signing below, I acknowledge that a completed Hardship Assistance Application does not guarantee funds and that grant awards will be based on the availability of funds. I certify that the statements herein are true, complete, and accurate. I also provide the required assurances and agree to comply with any resulting terms if I accept a grant award.

Parent Name (please print): _____

*Parent Signature _____ Date: _____

Social Work/Provider (print name):_____

Social Work/Provider Signature:_____ Date: _____

SW/Provider Email: _____ Phone: _____

Hospital: _____

Submit application to: emily@nomoreumbrellas.org | By mail: P.O. Box 313, Durant, FL, 33530

No More Umbrellas Foundation grants funds without regard to race, color, religious creed, gender, sexual orientation, disability, or national origin.

Optional Story