APPLICATION FOR ASSISTANCE
Use this checklist to help expedite your request.

REQUIREMENTS:
You must meet the following requirements before submitting an application.

☐ Child is age below 18
☐ Request qualifies as a valid health care need
☐ Child lives in St Louis and surrounding area
☐ Referred by a Social Worker or Case Manager or Therapist etc
☐ Request is for up to $1000

DOCUMENT CHECKLIST:
Submit below documents for faster processing of the request

☐ Complete Application form.
☐ Letter from a physician (on letterhead) providing the necessity of the equipment including the child’s diagnosis, history of illness, specific request for funding and other relevant information.
☐ Invoice from the provider.
☐ Child’s photo and story.
☐ Consent for publication.
☐ Missouri Children with Developmental Disabilities Waiver (MOCDD) a.k.a. Sarah Lopez Waiver denial letter. (If child has granted this waiver.)

CONTACT INFORMATION:
For questions regarding your application or The Arya Foundation, please contact us at:

The Arya Foundation
P O Box 4443
Chesterfield MO 63017

Phone: 314 445 ARYA (2792)
info@TheAryaFoundation.org
www.TheAryaFoundation.org
CHILD INFORMATION:

Name ________________________________  Age ____  Birth Date (MM)(DD)(YYYY)____
   Last          First                  Middle

Qualifying Medical Condition ______________________________________________________

Permanent Address ___________________________ Street Name ____________________________
                                                                                               City                     State            Zip Code

Current Address (if different from above) ___________________________ Street Name ____________
                                                                                               City                     State            Zip Code

FAMILY INFORMATION:

Parent / Legal Guardian’s Name ______________________________________________________
   ☐ Mother   ☐ Father   ☐ Other

Mailing Address ___________________________ Street Name ____________________________
                                                                                               City                     State            Zip Code

Home Telephone (    ) _____________________  Cellular/Work Telephone (    ) ____________

Email Address ________________________________________________________________

Parent / Legal Guardian’s Name ______________________________________________________
   ☐ Mother   ☐ Father   ☐ Other

Mailing Address ___________________________ Street Name ____________________________
                                                                                               City                     State            Zip Code

Home Telephone (    ) _____________________  Cellular/Work Telephone (    ) ____________

Email Address ________________________________________________________________

Child's Siblings Name/Ages ______________________________________________________
MEDICAL INFORMATION: (Health care professionals associated with current care)

Physician’s last name ___________________ First name ___________________ Title (DO, MD, etc) __________

Child’s clinical diagnosis ________________________________________________________________

History of illness/health condition ______________________________________________________

MEDICAL EQUIPMENT/SUPPLY:

Type of Equipment/supplies ____________________________________________________________

Cost of Equipment $ _____________________ Requested funding assistance $ _________________

If the total cost is more than $1000, how are the rest of the funds going to be paid _______________________

Provider that the check will be made out to ________________________________________________

Contact person at Provider _____________________________________________________________

Provider address __________________________________ Street Name __________________ City ______ State __________ Zip Code __________

Does your child have Missouri Children with Developmental Disabilities Waiver (MOCDD) a.k.a. Sarah Lopez Waiver? (Yes, Waitlisted, Not Applied) _________________________________

REFERRAL: (This is a requirement)

How did you hear about The Arya Foundation ________________________________________________

*Referred by organization, social worker, case manager, therapist etc:*

Organization name _________________________ Email __________________________

Referred person’s name _____________________ Title __________ Phone (_____) _________
AFFIRMATION AND CONSENT

In order for The Arya Foundation, a non-profit organization, to advance financial assistance for the purchase of medical supplies or equipment’s, the undersigned do hereby affirm as follows:

1. The undersigned are the parents or guardians of the child.

2. The undersigned further agree(s) to return any unused funds immediately to The Arya Foundation so that those funds can be utilized by the organization to benefit other families.

The Arya Foundation reserves the right to distribute funds at its sole discretion. The Arya Foundation may pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge. Please refer to the checklist at the top of page one of the application and attach all required documents prior to submitting the application.

I am 21 years of age or older, and have read and understand the above statements.

Child’s name (please print)_________________________________________ DOB __________________________

Parent/Guardian Name ____________________________________________

Parent/Guardian Signature __________________________ Date ________________

Address ______________________________ City ____________ State ______ Zip ___________

Parent/Guardian Name ____________________________________________

Parent/Guardian Signature __________________________ Date ________________

Address ______________________________ City ____________ State ______ Zip ____________