



# Friends Of Olivia Foundation

[www.friendsofolivia.org](http://www.friendsofolivia.org)

## APPLICATION FOR FINACIAL ASSISTANCE

**Please ensure that this application is filled out in full and all required documents are attached. Incomplete applications or applications that do not have the required documents attached, will be returned to the applicant unprocessed.**

Submission of this request authorizes the Friends of Olivia Foundation to contact organizations and individuals provided on this application, if necessary, for verification of financial and medical information. Applications will be reviewed on a monthly basis. Please allow 4-6 weeks for processing.

### General Information

Applicants Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_ F \_\_\_ M \_\_\_

Child's DOB: (mm) \_\_\_\_\_ / (dd) \_\_\_\_\_ / (yy) \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone Number ( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### Families / Legal Guardian Information:

Mother / Father or Legal Guardians Names:

\_\_\_\_\_  
\_\_\_\_\_

Number of siblings living in the home: \_\_\_\_\_

Ages of Siblings: \_\_\_\_\_

**Medical/Appointment Information:**

Referring Physician: \_\_\_\_\_

Date of Appointment \_\_\_\_\_ Expected Length of Stay \_\_\_\_\_

Health Care Facility : \_\_\_\_\_

Phone Number: \_\_\_\_\_ Floor/Rm # \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_

Social Worker: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

**Medical Diagnosis:**

*You must attach a copy of a medical assessment or letter written on hospital letterhead verifying child's diagnosis signed by a medical professional or social worker in order for your application to be processed.*

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**Request for Assistance Information:**

*The Friends of Olivia Foundation encourages each family to seek assistance from other programs that they may qualify for such as government and/or other organization.*

Purpose of Funds: Please list each request and the cost associated with it, in order from most important or critical to least critical. *please attach another page if needed*

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Please list the Government or Other Organization that you have requested assistance from. Explain their response. If they are providing funding please state amount and the terms of funding. *please attach another page if needed*

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**Financial Information:**

Mother's Employer: \_\_\_\_\_ PT \_\_\_ FT \_\_\_ Casual \_\_\_

Father's Employer: \_\_\_\_\_ PT \_\_\_ FT \_\_\_ Casual \_\_\_

If you are a single parent do you receive child support Y \_\_\_ / N \_\_\_ Amount \$ \_\_\_\_\_

Yearly Gross Household Income ( employment salary before taxes and deductions) \$ \_\_\_\_\_

***Please attach verification of income or a letter from your employer confirming gross income.  
If you are or will be on leave from work please attach a letter from your employer out lining the details of leave.***

Yearly Net Household Income ( employment salary after taxes and deductions) : \$ \_\_\_\_\_

***If you receive Social Assistance, please attach a copy of you most recent payment receipt.***

Please list other sources or income besides employment (Child Tax Credit, Universal Child Care Benefit, Disability Benefits, ) *please attach another page if needed*

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Do you receive funding from Assistance for Children with Severe Disabilities (ACSD)?  
(Y) \_\_\_\_\_ (N) \_\_\_\_\_

If yes, please state amount and provide a copy of your statement. \$ \_\_\_\_\_

**Special Request**

*Special requests will be reviewed by the Board of Directors and a decision will be made at their discretion.*

Please explain your request in very specific details including costs.  
*please attach another page if needed*

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**Household Expenses: (per month)**

Mortgage or Rent      \$ \_\_\_\_\_

Property Taxes        \$ \_\_\_\_\_

Utilities: Gas         \$ \_\_\_\_\_

    Hydro                \$ \_\_\_\_\_

    Water                \$ \_\_\_\_\_

    Phone                \$ \_\_\_\_\_

Child Care             \$ \_\_\_\_\_

Insurance: Home      \$ \_\_\_\_\_

    Car:                  \$ \_\_\_\_\_

Food:                    \$ \_\_\_\_\_

Loans:                  \$ \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Car - payments /fuel : \$ \_\_\_\_\_

Other (please describe) \_\_\_\_\_

\_\_\_\_\_

Please list any extraordinary child care expenses incurred as a result of the child's medical problems.  
*please attach another page if needed*

\_\_\_\_\_

\_\_\_\_\_

Total Monthly Expense: \$ \_\_\_\_\_

The Friends of Olivia Foundation recognizes the patient's right to privacy and pledges to protect it. We are aware of our responsibilities under the Federal Personal Information and Electronics Documents Act (PIPEDA). Our privacy policy endeavors to ensure that any individual's personal information is protected and appropriately handled. The information you provide on this document is only used for the purpose of determining eligibility. It is reviewed and handled only by those designated and authorized to do so within the Friends of Olivia Foundation office.

If your application is granted and a file is created, your secure file will be stored at our office for seven years (for audit purposes) after which time it will be shredded. Minimal information is kept indefinitely on our secure database.

***Our support is not illness or disease specific.***

***Applying to one of our programs does not guarantee our assistance. It guarantees careful consideration for financial aid by our Granting Committee.***

***We are committed to helping as many children and families from the District of Thunder Bay as possible with our limited funds.***

I have read and understand this application form in full. I have provided all the required information and documents.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail application to:**

Friends of Olivia Foundation  
2218 Isabella Street E.  
Thunder Bay Ontario  
P7E 5C6

**Or Fax to: (807) 622-4466**

***Our Mission*** ~ To assist children and their families when faced with unexpected life threatening illness or injury who are being sent from Thunder Bay Regional Health Science Centre by a physician to a medical centre outside the city of Thunder Bay.~ We believe nothing is more important than *Loving* them.

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**Office Use:**

Date received:

Notes: