The Elmhurst Children's Assistance Foundation
P.O. Box 291
Elmhurst, IL 60126
www.ecaf4kids.org ecaf@ecaf4kids.org

Please print this application, complete it in its entirety, and submit it to the above address.

APPLICATION FOR FINANCIAL ASSISTANCE

No application will be considered unless **all requested information is given.** Please write legibly.

Person completing form ____

Relationship to applicant ____

Date of application ____

APPLICANT INFORMATION:

Name ____

Address ____

Date of Birth ____________________ Age ____________________

School attending ____

Medical condition and/or disability (Please include letter of medical condition or disability from medical professional) ______________________________

PARENT/GUARDIAN INFORMATION:

Name ____

Relationship to applicant ____

Address ____

Present Occupation: __________________________ How Long?______________

Telephone (home) ____________________ Telephone (cell) ____________________

Email ____

FINANCIAL ASSISTANCE REQUEST INFORMATION

1. **Purpose for requesting financial assistance** (Please be specific):

2. **Total amount of assistance being requested** (Please itemize and **include documentation substantiating the amount of your request**):

3. **Name of primary health insurance provider**:

4. **Name of secondary health insurance provider** (if applicable):

5. **Additional sources of financial assistance** received (e.g. labor unions, social clubs, etc.):

PLEASE INCLUDE THE FOLLOWING REQUIRED INFORMATION WITH THIS APPLICATION:

1. **Proof of residency or employment** in Elmhurst
2. Most recent **tax form or W-2 form**
3. **Net worth worksheet** (included on the following page of this application)
4. A **letter from a medical professional** confirming the medical diagnosis of the applicant

FROM WHOM DID YOU LEARN ABOUT ECAF?

____ ECAF website

____ Newspaper

____ ECAF board member - Name of board member ______________________________

____ School professional - Name of school professional ___________________________

____ Medical professional - Name of medical professional _________________________

____ Other – Please specify ____

PLEASE NOTE: Any bills submitted must list the applicant and/or the applicant's parent(s) as the responsible payer. In the event that an application is approved, ECAF may make certain payments on behalf of the applicant family but the applicant family still bears the ultimate financial responsibility. ECAF is not to be billed directly or listed as the responsible payer on any accounts.

Statement by applicant: I certify that the information provided to the Elmhurst Children's Assistance Foundation in this application for assistance is true. I understand that false information will negate my request for funds. I understand that the decision to grant assistance is at the sole discretion of the Board of Directors.

Signature of Parent/Guardian ___________________________________ **Date** ____________

Revised: 8/20/12