Gabrielle Dinsmore Heart & Hope Fund

Information Regarding Financial Assistance

Gabrielle Dinsmore Heart & Hope Fund's mission is to be a recognized resource for providing educational, financial, emotional and recreational support to children and families in RI, CT and MA impacted by heart disease, congenital heart disease and severe feeding issues. We are a non-profit, 501(c)(3) organization.

The Fund has a budget of $10,000 per calendar year for the purpose of providing financial assistance to patients with congenital heart defects and severe feeding issues as a result of financial hardship. The Fund provides financial assistance for:

- Medicines not covered by insurance
- Clinical trials or programs not covered by insurance
- Utility payments
- Lodging during a pediatric hospital stay if accommodations are unavailable at the hospital

In order for the applications to be considered, The Gabrielle Dinsmore Heart & Hope Fund requires a letter from the pediatric cardiologist, feeding specialist, and/or Social Worker confirming the hospital stay and outlining demonstration of need. The Fund requires a copy of the utility statement, insurance statement or other bill which clearly demonstrates the balance owed. Documentation is also required for special medicines, programs, or trials which are not covered by insurance. **Monetary amounts can only be paid directly to an organization/utility company and will not be sent to individuals**. One application per family per year will be considered. No grant exceeding $2,500 will be awarded to a family.

If your request is approved, a member of our Financial Distribution Committee will contact you by telephone or email to let you know that you have been approved for assistance. A check will be sent directly to the utility, insurance company, etc. to cover the balance or part of the balance due.
The Financial Distribution Committee requires that applications be completed in its entirety and mailed to Ms. Lily D'Agnese, Chair of the Financial Distribution Committee of the Gabrielle Dinsmore Heart & Hope Fund at:

Ms. Lily D'Agnese
c/o Gabrielle Dinsmore Heart & Hope Fund
845 Oaklawn Avenue, Suite 203
Cranston, RI 02920

The Financial Distribution Committee will review all applications in a timely manner. If you have any questions prior to submitting your application, please email Lily D'Agnese at ldagnese17@gmail.com.
The Gabrielle Dinsmore Heart & Hope Fund reserves the right to accept and/or reject any application.
Tax returns may also be required during the reviewing process for proof of payments.

Gabrielle Dinsmore Heart & Hope Fund
Financial Application Form

Date: _____

Parent/Guardian Name:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Email Address:_____

Facebook Name:_____

Child's Name:_____

Birthday:_____

Congenital Heart Defect:_____

Feeding Issue:_____

Is your child Gtube, Nasogastric tube, or Orally fed?_____

Has your child been diagnosed with Failure to thrive?_____

Hospital where child is treated:_____

Address:_____

Primary Care Physician:_____

Cardiologist:_____

Phone Number and

Email:_____

Feeding Specialist:_____

Phone Number and

Email:_____

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Social Worker:_____

Phone Number and

Email:_____

Please describe any therapies that will not be covered by your insurance:

Cardiac Therapies:_____

Feeding Therapies:_____

***A letter from your child's cardiologist/feeding specialist and hospital social worker is required in order to be considered by the Financial Distribution Committee. Please have the medical provider include the child's diagnosis, current length of stay at the hospital and anticipated length of stay. Please also provide the anticipated cost of the required therapies, if they are not covered by insurance.**

Other Areas of Need

Brand of Gas most used:_____

Nearby Supermarkets:_____

Parking vouchers: (yes or no)_____

Cafeteria Vouchers: (yes or no)_____

Utility Assistance

Gas Company:_____

Account Number:_____

Phone Number:_____

Electrical Company:_____

Account Number:_____

Phone Number:_____

Mortgage Company:_____

Account Number:_____

Phone Number:_____

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Have you requested and/or received financial assistance from another organization within the last 12 months? (yes or no)_____

If yes, which organization?_____

After filling out this application in its entirety, please let us know what your needs are with the most important one first. This will help us to assist you effectively and meet your greatest need.

1. _____
2. _____
3. _____

Please note: All requests for financial assistance less than $500.00 will be considered in a timely manner by the Financial Distribution sub-committee. All requests of $501.00 and above will be reviewed by the sub-committee first and then be presented to the Board of Directors at the quarterly meetings. Please submit your completed application in accordance to the deadlines listed below:

Received by:	**Considered at:**
January 15	February Meeting
April 15	May Meeting
August 15	September Meeting
November 15	December Meeting