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*"...weep with those who weep."* *Romans 12:15*

11102 Sunrise Blvd. E., Suite 112, Puyallup, WA 98374 www.TheTearsFoundation.org

## Request For Financial Assistance for Infants

(20 Weeks Gestation to 1 year old)

**Today's Date**: _____ Date of Services _____ **State of Residence**: _____

**Baby's Full Name**: _____ Gender: Male Female

Birth Date & Time: _____ Death Date & Time: _____ Age at time of death: _____

**Was Baby Full Term: Yes No (circle one) Weeks of Gestation: _____ Was baby selectively terminated: Yes No (circle one)**

**If baby is a multiple will they be buried/cremated together or separately? _____**

Cause(s) of Death (circle one): Birth Defects Prematurity SIDS Stillbirth Other:_____

*If possible SIDS or Sleep related death, please fill out supplemental questionnaire)

List specifics if known_____

Servicing Hospital / Medical Examiner: _____

**List any Fundraising page links _____current amount raised_____**

**How will the funds raised be spent?** _____

Baby's Ethnicity for Statistical Purposes: (circle one) Mixed or Bi-racial (please specify) _____ Caucasian Asian

Hispanic African-American Native American Pacific Islander Middle Eastern Other (please specify) _____

**Mother's Full Name**: _____

Email: _____Birthdate: _____

Mother's Address: _____

City: _____ State: _____ Zip: _____ County: _____

Mother's Home Phone #: (_____) _____ Cell #: (_____) _____

Mother's Income: $_____ (circle one) annually / monthly / hourly

Mother's Employer: _____ Employer Ph. #: (_____) _____

**Father's Full Name**: _____

Email: _____Birthdate: _____

Father's Address (if same write "same"): _____

City: _____ State: _____ Zip: _____ County: _____

Father's Home Phone #: (_____) _____ Cell #: (_____) _____

Father's Income: $_____ (circle one) annually / monthly / hourly

Father's Employer: _____ Employer Ph. #: (_____) _____

Annual Household Income:$0-$16,000___$16,000-$32,000___$32,000-$65,000___$65,000+___

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**(Financial Assistance is for low income families. Families with high incomes must list extenuating circumstances to be considered forapproval.)**_____

Does the family receive State Assistance, SSI, or Food Stamps?_____

Marital Status: (circle one) Single-Living Together / Single-Not Living Together / Married / Divorced / Separated

Currently/Previously in Military? (circle one) Active Duty / Reserve or National Guard / Retired / Former Service Member (non-retired)

Names & Ages of children in home. _____

Preferred spoken and written language: _____

How did you hear about The TEARS Foundation? Please be specific. (i.e. Jane Doe of DSHS; John Doe Grief Counselor at Tacoma General)

_____

This is a need based application and to be used when all other options are exhausted. Please review this list for other resources that may be available to assist with your child's funeral expenses. The TEARS Foundation expects each of these areas to be explored prior to applying for assistance through The TEARS Foundation.

- State Assistance
- Tribal affiliation
- Religious Affiliation
- Hospital Foundation
- Family/Friends, Co-workers, Employer
- Military dependent
- Personal Savings/Credit Card
- GoFundMe page or other fundraising page

## WE CANNOT REIMBURSE FUNDS BACK TO FAMILIES. TO EXPEDITE, PLEASE CALL (253) 200-0944

**I verify that all the above information is true _____**
**(signature of parent)**

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***Please submit application within 30 days of services to be considered for assistance. For additional submission guidelines, please reference submission guidelines at www.thetearsfoundation.org or call (253) 200-0944.***

Name of Funeral Home: _____

Full Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

Name of Funeral Director: _____ Amount Requested: _____

Burial _____ Cremation _____ Is family eligible for state, military, or other funeral benefits? Yes No (circle one)

Name, address and phone number of place of interment: _____

_____

Was there a balance left for funeral costs, beyond what TEARS is paying for? Yes No (please circle one)

If yes, please list the amount and items remaining for payment, and how the balance is being paid for. _____

**We are accepting completed applications via the following methods: If you have not heard from us in 48 hours, call to confirm we received your application.**

**Fax:** 253-848-0299 **E-mail:** office@thetearsfoundation.org
**Mail:** 11102 Sunrise Blvd E, Suite 112 - Puyallup, WA 98374

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# TEARS Foundation Supplemental Questionnaire

## **Please fill out for potential SIDS or sleep related infant deaths

***This information will aid us in future research & data to help prevent infant loss. Thank you for supporting these efforts.***

Baby's Name (first and last) _____

1. How old was your baby? _____
2. Where was baby was sleeping at the time of death:

   _____Parent's bed
   _____Stroller
   _____Car Seat
   _____Couch
   _____Another family member/friend's bed
   _____ In their crib
   _____ Other – please describe
3. Was baby sleeping on his/her back or stomach?
   _____
4. If baby was sleeping in a crib, did the crib have loose blankets/comforter, or stuffed animals, bumper pads, or pillows in it?
   ____Yes
   ____No
5. Was baby born at a low birth weight or born prematurely?
   ____Yes
   ____No
6. Does anyone in the household smoke cigarettes?
   ____Yes
   ____No
7. Was baby sleeping with an adult at the time of death?
   ____Yes
   ____No

Our hearts go out to you at this time of devastating loss. Thank you so much for providing this information and helping us in our attempt to research and reduce SIDS and infant deaths.

You are not alone and if you would like additional emotional support, please contact us at 253-200-0944.

For office use: State _____ Date of Death _____ _____