



...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 R	esidence:
Baby's Full Name:				Gender: Male Female
Birth Date & Time:	Death Date & Time:		Age a	t time of death:
Was Baby Full Term: Yes No (circle	one) Weeks of Gestation:			
*Unfortunately, if you had to make the h	eartbreaking decision to terminate yo	ur pregnancy, we wi	II not be able to o	offer financial assistance due to sheer
volume of requests. However, know that	we welcome you with open arms to p	articipate in our ever	nts and seek emo	tional support with us.
If baby is a multiple will they be	e buried/cremated together	or separately? _		
Cause(s) of Death (circle one): Birth [Defects Prematurity SIDS	Stillbirth Ot	her:	
*If possible SIDS or Sleep related de	ath, please fill out supplementa	l questionnaire)		
List specifics if known				
Servicing Hospital / Medical Examir	ner:			
List any Fundraising page links				
How will the funds raised be spen	t?			
Baby's Ethnicity for Statistical Purp	oses: (circle <u>one</u>) Mixed or Bi-racia	al (please specify)		Caucasian Asian
Hispanic African-American Nat	ive American Pacific Islander	Middle Eastern	Other (please	specify)
Mother's Full Name:		·		
Email:				Birthdate:
Mother's Address:				
City:				
Mother's Home Phone #: ()	(Cell #: ()		
Mother's Income: \$ (c	ircle one) annually / monthly / hou	rly		
Mother's Employer:	Employ	er Ph. #: ()	
Father's Full Name:				
Email:				Birthdate:
Father's Address (if same write "same"): _				
City:				
Father's Home Phone #: () _				
Father's Income: \$ (circl				
Father's Employer:			_)	
Annual Household Income:\$0-\$16				



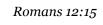


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inancial Assistance is for low income families. Families with high incomes must list extenuating circumstances to be considered
prapproval.)
oes the family receive State Assistance, SSI, or Food Stamps?
larital Status: (circle one) Single-Living Together / Single-Not Living Together / Married / Divorced / Separated
urrently/Previously in Military? (circle one) Active Duty / Reserve or National Guard / Retired / Former Service Member (non-retired)
ames & Ages of children in home
referred spoken and written language:
ow did you hear about The TEARS Foundation? Please be specific. (i.e. Jane Doe of DSHS; John Doe Grief Counselor at Tacoma General)
nis is a need based application and to be used when all other options are exhausted. Please review this list for other resources that
ay be available to assist with your child's funeral expenses. The TEARS Foundation expects each of these areas to be explored prior
applying for assistance through The TEARS Foundation.
• State Assistance • Family/Friends, Co- • Personal Savings/Credit
• Tribal affiliation workers, Employer Card
• Religious Affiliation • Military dependent • GoFundMe page or
Hospital Foundation other fundraising page
VE CANNOT REIMBURSE FUNDS BACK TO FAMILIES. TO EXPEDITE, PLEASE CALL (253) 200- 944
verify that all the above information is true ignature of parent)
lease submit application within 30 days of services to be considered for assistance. For additional submission guidelines, please eference 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.





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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 bedStrollerCar Seat
- - -	CouchAnother 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? YesNo
5.	Was baby born at a low birth weight or born prematurely?YesNo
6.	Does anyone in the household smoke cigarettes?YesNo
7.	Was baby sleeping with an adult at the time of death? YesNo
	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 o	office use: State Date of Death