Give One Dollar a Day is dedicated to helping ease the financial burden of families and children who are affected by illness, poverty, and isolation.

Information For Financial Assistance

(to be completed by legal guardian and child's social worker– PLEASE PRINT)

Social Worker's Name:_____ Date of Application Submitted _____

Name of Affiliated Hospital:_____

Child's Name: _____

DOB: _____ Gender: _____

Annual Household Income _____

(Information will be used for statistical purposes only and will not affect eligibility.)

Diagnosis: _____ Date of Diagnosis: _____

Service Request – Description of need. Please provide exact amount of dollar request.

_____

_____

Parent/Legal Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Email: _____

Language Spoken: _____

Make Check Payable to: _____

Address you would like the check sent to:_____

_____

Signature: _____ Date: _____

- By signing this application, you agree that your story can be used by Give One Dollar A Day for marketing purposes including websites, social media, and other fundraising materials to promote our mission and help support more families in need. Last names and medical records will not be shared.
- Upon receipt of the gift/donation there is no ongoing obligation, liability, or fiduciary duty on the part of Give One Dollar a Day.

☐ Please check box if you are open to being contacted by Give One Dollar A Day staff to further share your story including possible interviews, photos, and details.

Please send this application to ***donate@giveonedollaraday.org***

(Social Worker: Please attached a separate page with a brief narrative of the social situation and financial need)