Application For Assistance

P.O BOX 24877 TEMPE, AZ 85285 | SUZYFOUNDATION.ORG

To Qualify

Suzy Foundation is passionate about helping individuals with special needs. Please complete the entire application below and attach the necessary documents.

1. Include a letter or prescription from the applicant's doctor confirming the need for the requested assistive device.

2. A copy of parent(s)/guardian(s) most recent Income Tax Return (IRS Form 1040) with copies of all supporting W-2 forms. For your security all information is confidential and treated with the utmost sensitivity. Please black out your social security number. All documents will be shredded once a decision has been made.

3. Letter of denial from parent(s)/guardian(s) insurance company.

4. Your application will be valid one year from its submission date.

5. Incomplete applications will not be accepted. If denied, Suzy Foundation will review your application throughout the year if additional information is submitted for reconsideration.

6. Suzy Foundation considers each applicant on an individual basis.

7. Please mail completed application to Suzy Foundation, P.O. BOX 24877, Tempe, AZ 85285 or submit online

8. Must live in the Phoenix/metropolitan area

9. Individuals may only receive assistance once per calendar year.

Please be advised that the Suzy Foundation will directly purchase the assistive device for the applicant. Suzy Foundation does not provide funds directly to individuals.

Suzy Foundation Staff Only

☐ **Approved** ☐ **Denied**

Description of approval:

_____

_____

Staff Signature:

_____

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Name of Individual

First Name: _____ **Last Name:** _____

Date of Birth: _____

Name of Person Completing the Form

First Name: _____**Last Name:** _____

Relationship to Individual: _____

Phone Number:_____ **Email Address:**_____

☐ Preferred Method of Contact ☐ Preferred Method of Contact

Person To Contact If Selected

Parents/Guardians Name: _____

Home Address: _____

Phone Number:_____ **Email:** _____

☐ Preferred Method of Contact ☐ Preferred Method of Contact

If selected, I give my authorization for Suzy Foundation to use the applicants image and story on our website and fund-raising information?

☐ Yes
☐ No

How did you hear about us?

_____

_____

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What is the assistive condition of the individual and please explain how this condition affects the individual:

_____

_____

_____

_____

What assistive device are you requesting?

_____

What is the cost of the assistive device?

_____

Please provide purchasing information for this device.

_____

_____

Have you attempted to obtain this device through insurance?

- ☐ **Yes**
- ☐ **No**

If not covered by your insurance, please attach an official letter of denial from your insurance provider.

What benefit would the medical device provide for the individual? Is there any additional information you wish to share with us in support of your application?

_____

_____

_____

Did You Attach? ☐ **Dr. Prescription** ☐ **Income Tax Return** ☐ **Every Question Answered**

☐ **Insurance Denial Letter** ☐ **Other** _____