

REQUESTING ASSISTANCE

HOW WE HELP

ANA's **SEOLE Program** provides financial assistance for families of **stillborn** children. Through this program ANA is able to assist with expenses related to: * Autopsy * Funeral/burial * Cremation * Cemetery Plot * Headstone/Monument

Additionally, ANA's **GRASP Program** provides funding for bereaved families in need who are seeking the support of a counselor to address grief related to baby's stillbirth.

HOW IT WORKS

- ✚ After receiving a Request for Assistance (RFA) form, ANA volunteers confirm information and eligibility.
 - ANA volunteers follow up with the service providers and families/requestors to confirm current account balances and explain ANA's mission and programs.
 - If baby was stillborn, volunteers determine ANA'S contribution based on pre-established protocol.
 - ANA cannot reimburse families for expenses already paid.

- ✚ If the RFA is complete and meets eligibility requirements, volunteers continue to process the application and coordinate disbursement of funds.

- ✚ ANA's contribution is always the final payment on the account, and families must coordinate their payments with the service provider (i.e. funeral home).

- ✚ When the account balance matches the amount ANA has pledged, the provider must submit an invoice to ANA showing payments and an updated balance. We will then submit final payment directly to the service provider.

- ✚ ANA is staffed entirely by volunteers and we do our best to process requests in a timely manner. However, sometimes it takes longer than we anticipate. We appreciate your patience as we do our best to help you.

ELIGIBILITY

To qualify for consideration for the SEOLE or GRASP program, the following must be true:

- You live in the United States.
- Your baby was stillborn (i.e. born at/after 20 weeks' gestation, with no signs of life (heartbeat, respirations, etc.)).

HOW TO REQUEST ANA'S HELP

1. Complete this form and attach copies of itemized invoices you need help paying.
2. Send form and attachments to ANA via USPS, fax or email.

An ANA representative will contact you within a week. You may also call ANA directly at (518) 654-2411.

REQUEST FOR ASSISTANCE (RFA) FORM

PART I: FAMILY INFORMATION

Your Name: _____ Relationship to baby: _____
Baby's name: _____ Baby's DOB/DOD: _____
Baby's Gestational Age (i.e. month of pregnancy when baby was born): _____
Address: _____ City, State, Zip: _____
Phone(s): Home: () _____ Cell: () _____ Fax: () _____ Email: _____

PART II: REFERRAL SOURCE(S)

Referred by (name): _____ Title: _____
Relationship (circle one): Colleague Family Member Friend Funeral Home Hospital Staff Internet Other _____
Address: _____ City, State, Zip: _____
Phone(s): Home: () _____ Cell: () _____ Fax: () _____ Email: _____
Signature: _____ Date: _____

PART III: SEOLE PROGRAM - EXPENSES

Please note the services below for which you are requesting financial assistance and attach copies of invoices. Payment, if approved, will be sent directly to the service provider once the account balance matches ANA's pledge.

1. Autopsy

a. Hospital/Laboratory: _____ Contact (if known): _____
b. Address: _____ City, State, Zip: _____
c. Phone: () _____ Fax: () _____ Email: _____
d. Financial Need: \$ _____ Invoice attached

2. Funeral/Burial

a. Funeral Home: _____ Director: _____
b. Address: _____ City, State, Zip: _____
c. Phone: () _____ Fax: () _____ Email: _____
d. Financial Need: \$ _____ Invoice attached

3. Cremation

a. Crematorium: _____ Contact: _____
b. Address: _____ City, State, Zip: _____
c. Phone: () _____ Fax: () _____ Email: _____
d. Financial Need: \$ _____ Invoice attached

4. Cemetery Plot & Foundation

a. Cemetery: _____ Contact: _____
b. Address: _____ City, State, Zip: _____
c. Phone: () _____ Fax: () _____ Email: _____
d. Financial Need: \$ _____ Invoice attached

5. Headstone

- a. Company: _____ Contact: _____
- b. Address: _____ City, State, Zip: _____
- c. Phone: () _____ Fax: () _____ Email: _____
- d. Financial Need: \$ _____ Invoice attached

6. Stationary (birth/death announcements, thank you notes)

- a. Stationer/Printer: _____ Contact: _____
- b. Address: _____ City, State, Zip: _____
- c. Phone: () _____ Fax: () _____ Email: _____
- d. Financial Need: \$ _____ Invoice attached

PART IV: GRASP PROGRAM - Grief Recovery Assistance Program (GRASP)

- Provider name: _____ (circle one): MD/PhD/CSW/MSW
 Practice/Business Name: _____
 Address: _____ City, State, Zip: _____
 Phone: () _____ Fax: () _____ Email: _____
 Financial Need: \$ _____ Invoice attached

PART V: ELIGIBILITY & RELEASE

ANA reserves funding for families with the greatest need. What financial resources do you currently have?

- I have received/expect to receive the following assistance for the expenses indicated on this form:**
 - o Donations from: (circle all that apply) family, friends, colleagues, church groups, etc.
 - Amount(s): \$ _____
 - o Donations from other organizations (government*, nonprofit, etc.; please list): _____

**You may be eligible for assistance through Social Services or Medicaid. Call them directly or ask your funeral director to help you apply.*

- Amount(s): \$ _____

- I am not receiving/do not expect to receive financial aid from other sources for the expenses indicated on this form.**

I authorize ANA and its representatives to discuss with the providers listed in Part III of this form, my financial obligations as indicated on the attached invoices.

Signature _____ Date _____

Funding for the *SEOLE* and *GRASP* programs is made possible primarily through donations from families of stillborn babies. You can help!

- ♥ Tell friends, family and colleagues about ANA's mission, and encourage them to donate to ANA in your child's memory.
- ♥ Add the ANA contact information to your child's obituary.
- ♥ Share info. about ANA in your communications (i.e. mail, email, social media/Facebook/Twitter/Instagram)