ANGEL NAMES
Association

Request for Assistance (RFA)

To request assistance through the SEOLE or GRASP program, please complete this form and return, along with copies of invoices for services noted, to Angel Names Association, PO Box 423, Saratoga Springs, NY 12866. An ANA representative will contact you within a week. If you require more immediate assistance, please call 654-2411.

PART I: FAMILY INFORMATION

Your Name: _____ Baby's name: _____
Relationship to baby: _____
Address: _____
City, State, Zip: _____
Phone: ( )_____ Fax: ( )_____ Email: _____

PART II: REFERRAL SOURCE(S)

Referred by (name): _____
Address: _____
City, State, Zip: _____
Phone: ( )_____ Fax: ( )_____ Email: _____
Signature: _____ Date: _____

PART III: SEOLE PROGRAM

The SEOLE (Securing End-of-Life Expenses) program, pronounced "soul," provides financial assistance to families of stillborn babies as they face the myriad of expenses relating to their baby's death.

Expenses
Please check 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 and a copy will be sent to you.

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

2. Funeral/Burial
   a. Funeral Home: _____ Director: _____
   b. Address: _____
   c. City, State, Zip: _____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

3. Cremation
   a. Crematorium: _____ Contact (if known): _____
   b. Address: _____
   c. City, State, Zip: _____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

4. Cemetery Plot & Foundation
   a. Cemetery: _____ Contact (if known): _____
   b. Address: _____
   c. City, State, Zip: _____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

5. Headstone
   a. Company: _____ Contact: _____
   b. Address: _____
   c. City, State, Zip: _____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

6. Stationary (birth/death announcements, thank you notes)
   a. Stationer/Printer: _____ Contact: _____
   b. Address: _____
   c. City, State, Zip: _____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

PART IV: GRASP PROGRAM

The Grief Recovery Assistance Program (GRASP) provides funding for uninsured and underinsured families pursuing counseling services to work through the grief of stillbirth.

Provider name: _____ (circle one): MD/PhD/CSW/MSW
Address: _____
City, State, Zip: _____ Phone: _____
Financial Need: $_____ ❒ Invoice(s) attached

PART V: ELIGIBILITY & RELEASE

The ANA reserves funding for families with the greatest need, and may not provide financial assistance to those who are receiving benefits from another agency.

❒ I am not receiving/do not expect to receive financial assistance from other sources for the expenses indicated on this RFA.
❒ I have received/expect to receive the following assistance: _____
_____
_____

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

_____
Signature Date

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

Saratoga County Dept. of Social Services, Temporary Assistance Office: (518) 884-4137
Medicaid Helpline: (518) 486-9057
New York State Dept. of Health online: www.health.state.ny.us

Funding for the SEOLE and GRASP programs is made possible primarily through donations from families of stillborn babies. Please consider asking your friends and/or family to donate to ANA. You may also add the ANA contact information below to your child's obituary.