Project Sweet Peas  
**NICU Family Financial Assistance Application**  
*Please review the eligibility requirement and entire application prior to submission*

**Parent/Guardian Information:**  
First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Cell Phone Number:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

E-Mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Patient Information:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F  
  
Multiples (*Please Circle One*): *List firstborn child above only*  
  
 Twins Triplets Quadruplet Quintuplet Other

Medical Insurance Provider (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital Information:**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Approximate distance from your residence**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Current means of transportation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Are you currently living at a location other than your residence during your child’s treatment?** Yes No  
If yes, please list the following information:  
  
Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current annual household income** (*Please Circle One*):   
  
 Less than $10,000

$10,000 - $19,999

$20,000 - $29,999

$30,000 - $39,999

$40,000 - $49,999

$50,000 - $59,999

$60,000 - $69,999

$70,000 or above

**Please list the people, including yourself, currently residing in your household.  
Name Date of Birth Relationship**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please list the current expenses related to your child’s NICU hospitalization or treatment:**  
  
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**Please explain why financial assistance is needed and if grant is awarded what it would be used for:**  
  
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This section is to be completed by your child’s NEONATOLOGIST, SOCIAL WORKER, OR NEONATALOGY NURSE PRACTIONER.   
  
Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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Date of Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Projected Release Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
  
Medical Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Hospital/Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please describe the current (include dates last treated) and anticipated course of treatment for the child(ren) listed above:  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I attest that the above patient(s) has/had an in-patient stay in the neonatal intensive care unit longer than two weeks and is receiving/was receiving care for such described above.  
  
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**Provider’s Name Signature Date**

**Checklist for Project Sweet Peas NICU Family Grant Application**Before submitting your application, please make sure you have read over the Eligibility Requirements, and have included the following information. *Failure to include all of the information could result in delays or a denial of funding.* **\_\_\_\_\_\_\_\_\_\_\_ Read and understood Eligibility Requirements  
  
\_\_\_\_\_\_\_\_\_\_\_ Completed and signed application  
  
\_\_\_\_\_\_\_\_\_\_\_ Completed and signed Medical Provider section  
  
\_\_\_\_\_\_\_\_\_\_\_ Copy of Driver’s License or State Photo Identification   
  
\_\_\_\_\_\_\_\_\_\_\_ Completed Media Consent  
  
  
Mail application to:**

**Project Sweet Peas  
Attn: NICU Family Grant Application  
45 Boylston St**

**Warwick, RI 02889**

**Or email application to:**

**info@projectsweetpeas.com**

I have read and understand Project Sweet Peas’ guidelines. By signing below, I agree that that the information on this form is true and correct to the best of my knowledge. I attest that any financial funding if awarded will be utilized for the expenses listed above. I release Project Sweet Peas’ responsibility for fund allocation after funds distribution. I understand that all applications will be reviewed individually and that I am not guaranteed funding based upon submission of my application.

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Parent/Guardian Name Signature Date**

**Media Consent Form**

Your signature on the consent form below is greatly appreciated, as it will allow us to use photographs and interviews for this program. Photographs and interviews may be used by Project Sweet Peas to tell the stories of participants of the NICU Family Grant program. Photographs and interviews may be used for informational, soliciting donations, press and/or marketing materials.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Project Sweet Peas to contact me to use my name, my child’s name and photographs or interview for printed materials, electronic media, or for purposes of press coverage, marketing, display or exhibition.   
  
  
Name of minor child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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Parent/Guardian Name Signature Date**

**\_\_\_\_\_ I do want my/my child’s photo or quotes to be used  
  
\_\_\_\_\_ I do not want my/my child’s photo or quoted to be used**

***Project Sweet Peas’ Family Grant Eligibility FAQ***

* **Who is eligible to receive assistance from Project Sweet Peas?**
  + You must currently have an infant(s) receiving inpatient care in the Neonatal Intensive Care Unit, Special Care Unit, or Specialty Pediatric Hospital. Your infant(s) must have been in inpatient care longer than two weeks.
* **Is there an age limit to apply?**
  + Parents must be over the age of 18 and the infant(s) must be under one year of age.
* **What bills or costs can be covered?**
  + Funds may be used for the following: Medical Bills incurred from infant's NICU stay, living expenses including rent, mortgage, electricity, gas, car payment and waste, (funds may not be utilized for cable television, internet or wireless payments) Medical equipment including breastfeeding supplies & resources and prescription medications for the infant, parent lodging required for infant's stay, food expenses for parent required during infant's stay, childcare for infant's siblings and transportation including bus and cab fees as well as gas for personal vehicles.
* **What paperwork must be filled out?**
  + Your application submittal must include the Parent/Patient Information Form, the Medical Professional Form, a copy of a state driver’s license or photo I.D. and the media consent form.
* **Is every application approved?**
  + No, due to limited funding grants will be awarded monthly.
* **How long before I hear about my submission?**
  + Grants are currently reviewed monthly but you will hear from a member of Project Sweet Peas within a week of submitting your forms.
* **When will I receive my funding?**
  + Not all submissions are awarded, but if chosen, you will receive a visa gift card by the 15th of the following month.
* **Am I guaranteed to have all of my bills paid for?**
  + Unfortunately, no. Grants are limited to $200, no matter the family’s financial need.
* **How often can I apply?**
  + You can apply as often as you would like but grants are reviewed monthly.
* **I was awarded a grant in the past, can I apply again?**
  + If you have previously been awarded a grant you must wait one calendar year before submitting another request.
* **I do not have custody of the infant, can I apply?**
  + No, you must have full legal custody of the infant at the time submitting for assistance.