



**VARIETY FINANCIAL ASSISTANCE APPLICATION**

11840 Westline Industrial Dr • Suite 220 • St. Louis, MO 63146  
Medical Equipment: 314-720-7708 Therapy: 314-720-7720 • Fax: 314-731-6866

**Child's Information**

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Child's Primary Diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_

Additional Diagnoses:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent/Guardian's Information**

Primary Guardian(s): \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Primary Address: \_\_\_\_\_

City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_

County: \_\_\_\_\_

Home: Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

\*Your response to the following question is optional and will not affect the status of your application. The information requested is useful to St. Louis Variety in grant applications and other activities seeking additional funding for our assistance programs.

What is your child's race/ethnicity:

- African American     Asian/Pacific Islander     Caucasian     Eastern European  
 Hispanic/Latino     Native American     Multi-Racial     Other

**Medical Supervisor:** (List Name, Address and Telephone Number of Physician, Therapist or Others Involved in Treatment)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Request**

Nature of Request (Orthopedic Equipment, Wheelchair, Therapy, Etc.)

\_\_\_\_\_  
\_\_\_\_\_

Estimated Cost: \$ \_\_\_\_\_  
Supplier: \_\_\_\_\_

If you have health insurance, list company name(s): \_\_\_\_\_

If insurance covers any portion of needed equipment, how much or what percent? \_\_\_\_\_  
\_\_\_\_\_

School or Program Child attends: \_\_\_\_\_ School District: \_\_\_\_\_

**Names & Ages of Any Other Children Residing at Home:**

<u>Name</u>	<u>Age</u>	<u>Name</u>	<u>Age</u>
1.		3.	
2.		4.	

**Household Income Information**

Number of earner's in the household: \_\_\_\_\_ Number of members of the household: \_\_\_\_\_

Earners #1's income per Year: \$ \_\_\_\_\_ Per Month: \$ \_\_\_\_\_

Occupation and Current Employer: \_\_\_\_\_

Company Address: \_\_\_\_\_

How long have you been employed by this employer? \_\_\_\_\_

Earners #2's income per Year: \$ \_\_\_\_\_ Per Month: \$ \_\_\_\_\_

Occupation and Current Employer: \_\_\_\_\_

Company Address: \_\_\_\_\_

How long have you been employed by this employer? \_\_\_\_\_

**Please provide copies of your most recent W-2 for each earner in the household as well as a copy of the first two pages of your most recent federal income tax return (Form 1040) or equivalent (award letter). These can be faxed to Misty Burton at 314-731-6866 or mailed to 11840 Westline Industrial Dr, STE 220, St. Louis, MO 63146.**

**If your adjusted gross income is over \$85,000 please also complete the detailed expenses section below.**

**MONTHLY INCOME**

ALL Household Earner's Take Home Pay \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Maintenance \$ \_\_\_\_\_

Social Security \$ \_\_\_\_\_

Other Income – Pensions, Dividends, Rents, Relatives, etc. \$ \_\_\_\_\_

**TOTAL ESTIMATED MONTHLY INCOME** \$ \_\_\_\_\_

**MONTHLY EXPENSES**

Monthly Housing Payment (mortgage, rent) \$ \_\_\_\_\_

Monthly Utilities Payment (gas, electric, water) \$ \_\_\_\_\_

Monthly Car Payments \$ \_\_\_\_\_

Other Monthly Debt Payments

    Student Loans \$ \_\_\_\_\_

    Credit Card Loans \$ \_\_\_\_\_

    Bank Loans \$ \_\_\_\_\_

    Medical Bills \$ \_\_\_\_\_

Childcare Expenses (daycare, babysitting, etc) \$ \_\_\_\_\_

Therapy Expenses \$ \_\_\_\_\_

Medicine \$ \_\_\_\_\_

Special food for special diet for child(ren) \$ \_\_\_\_\_

Other significant monthly expenses (please specify) \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL ESTIMATED MONTHLY EXPENSES** \$ \_\_\_\_\_

Describe any extraordinary expenses or special circumstances. Be specific as to the expense and anticipated duration of the circumstances.

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If you receive aid from other sources such as Missouri Special Health Care Needs, Medicaid, Sara Lopez waiver, etc.) please list them here:

What is the estimated monetary value of this assistance annually: \_\_\_\_\_

How did you hear about Variety? \_\_\_\_\_

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Parent or Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Assessments**

The equipment that we provide will not be possible without the many generous individuals, companies, and foundations within the Greater St. Louis community who contribute to Variety. Our programs depend on the giving hearts of these benefactors. With that in mind, we will ask you to share with us how your child's piece of equipment has positively impacted his/her life, and that of your family.

Your responses will be critical to increasing funding for this important program, and all responses will be kept confidential unless you grant specific permission to share your identifying information. Please help us to help more children with physical and developmental disabilities by completing the assessment

**I understand that I will be asked to complete an assessment as part of my Variety application if I am given equipment/services.**

Parent or Guardian Signature: \_\_\_\_\_