Family Support Grant Application

All Information is confidential. Incomplete applications will be returned. (PLEASE PRINT)

Please send this ***completed application by encrypted Email to specialcare@sk-sc.org. A confirmation receipt will be sent to you within 2-3 days. If you have any questions, please contact Barbara at specialcare@sk-sc.org or720-480-5367.***

AGENCY		**DATE**	
CONTACT NAME		**TITLE/POSITION**	
ADDRESS		**CITY/ZIP**	
EMAIL		**PHONE/TEXT:**	

FAMILY INFORMATION REQUIRED

CHILD'S NAME		**BIRTHDATE**		**GENDER**	☐ **Male** ☐ **Female**
HOSPITAL		**GESTATION**		**BIRTHWEIGHT**	
MOTHERS NAME		**FATHERS NAME**			
ADDRESS/APT.		**APARTMENT #**		**CITY**	
ZIP CODE		**COUNTY**			
EMAIL		**PHONE/TEXT #**			

LANGUAGE:	**English**	**Spanish**	**Other:**	
RACE/ETHNICITY:	⎦ Asian	⎦ AA/ Blk	⎦ Cauc./Non-Hisp.	⎦ Cauc./Hisp.	⎦ Other
INSURANCE:	⎦ None/self	⎦ Medicaid	⎦ Medicaid/Private	⎦ Private	⎦ Other
REFERRALS:	⎦ Early Intervention		⎦ HCP	⎦ NFP	⎦ Other

FAMILY APPROVES OF REQUEST: **YES** **IDENTIFY OTHER CHILDREN AND AGES BELOW**

REQUESTED SUPPORT SERVICES

	NICU Home Discharge Support Phone Follow-up Program
	Infant Crib and Parent Education Information
	In-home Lactation Consultation
	Respite Care
	Infant supplies, equipment, developmental toys
	Other:

HOW WILL THIS GRANT ASSIST BABY AND FAMILY?

SIGNATURE

Special Kids, Special Care, Follow up Report

Date Received:	**Referral Source Notified**
Family Contacts and Follow-up	
FEEDBACK: ☐ Family connected with referrals ☐ Assisted with referral follow-up	
Unable to Contact Family: ☐ No phone service/incorrect number ☐ No responses to a phone call ☐ No response to a letter	