



P.O. Box 2616 Newnan, GA 30264

Keris Kares, Incorporated (KKI)
Grant Application for Financial Assistance

“Rejoice always, pray without ceasing, in everything give thanks; for this is the will of God in Christ Jesus for you.” 1 Thessalonians 5:16-18

It is our mission to provide hope for families dealing with a childhood cancer diagnosis by providing spiritual, emotional, and financial support. We will raise awareness about pediatric cancers and provide monetary assistance to research being conducted to find a cure.

In support of this mission, Keris Kares, Incorporated provides supplementary financial assistance to families with financial needs resulting from a pediatric cancer diagnosis. The grant covers non-medical costs such as: rent/mortgage payments, utility bills, car loan and car insurance payments. All checks will be made payable to the creditor or bill providers and not the parent or guardian for the child.

To qualify for assistance:

1. The patient must be a child (under 18 yrs @ time of application; must include D.o.B. to verify).
2. The patient must be undergoing treatment for a pediatric cancer.
3. The request must be validated by written statement from the doctor or Social Worker.
4. The application must include a copy of the bill that will be paid and include a description (type of bill, dates of service, amount requested, remittance address, payee name, etc.).
5. Families are eligible to receive one Family Assistance grant every 12 months with a maximum award of \$1,500 in that period of time.

Financial Assistance is based on availability of funds. Complete applications will be reviewed in the order received. All protected information is strictly confidential. Once reviewed, KKI will contact the grant submitter to confirm the application has been accepted or declined. Please allow five to seven business days for a response. All grant applications must be received by December 7th in order to be reviewed within the current calendar year.

Please send grant related questions and/or complete application packets to: grants@keriskares.org
Hard copies can be mailed to: P.O. Box 2616 Newnan, GA 30264.
Only complete applications will be reviewed.



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Grant Application for Financial Assistance Applicant Information

Applicant's Full Name: _____
Last First M.I. Relationship to Patient

Address: _____
Street Address Apartment/Unit#

_____ *City State Zip Code*

Primary Phone: () _____ Email Address: _____

Patient's Name & D.o.B. _____

Bill Description, Amount Requested, Payee Name & Payment Mailing Address (attach a copy of the bill):

Patient Information

Please provide a brief description of illness including date of diagnosis and treatment plan here.

Please list the name and contact information of your child's primary doctor & current treatment facility.

Please list two references and provide his/her complete name and best number for contact.

Is the patient and/or applicant willing to share their story about how Keris Kares has made their journey with adversity easier? If so, our Outreach Team may contact you.

****Answers to this question are not considered during the grant approval process.****

YES NO

How did you hear about Keris Kares:

Social Worker Social Media Website Individual Other

I hereby consent that the medical records provided may be made a part of my application for assistance to Keris Kares, Incorporated, or its officials. I understand that my application cannot be processed until I have submitted all required documents to the address shown on the top (or email at the bottom) of this application. By signing below, I certify that this request has been made voluntarily, that I have read and understand this application, and that the information given above is accurate to the best of my knowledge.

X _____
Applicant's Signature

Date