Incredible Teddy Foundation
PO Box 3122
Saratoga Springs 12866
www.incredibleteddyfoundation.org

May 2018

The Incredible Teddy Foundation was formed in 2010 by Teddy's parents, Phil and Andi Lodico. They have lived and learned firsthand many of the hardships faced by families who are fighting Congenital Diaphragmatic Hernia (CDH). CDH is an extremely complicated health condition that often affects children throughout their lives, placing a tremendous amount of stress on families.

The Incredible Teddy Foundation's goal is to assist children born with CDH, as well as their families, with the hope of lessening some of the emotional and financial burdens, and bringing comfort in times of struggle. We provide financial support for medical travel, costs incurred with prolonged hospital stays, and other family related expenses associated with having a child with CDH.

Grant Eligibility: Grants are limited to children born with CDH and their immediate families, or to expecting parents of a CDH newborn.

Grant Criteria:

- Completion of the following application with signature of the primary care physician, obstetrician, or pediatrician, whichever is applicable.
- Grants will be awarded up to $2000.
- Applicants may apply more than once, but for not more than $2000/year.
- Grants will be reviewed six times per year by the Board of Directors and subsequently awarded.
- Grants will be awarded as reimbursement for expenses incurred.
- Applications must be submitted with receipts in order for grants to be awarded.

Housing Requests at Boston Children's Hospital:

The Incredible Teddy Foundation provides funds for housing in the Patient-Family Housing program at Boston Children's Hospital through Teddy's Home Away from Home Fund. If requesting funds for housing costs at Boston Children's Hospital, demonstration of an attempt to access Teddy's Home Away from Home Fund must accompany this application. To learn more about how to access Teddy's Home Away from Home Fund, contact us at believe@incredibleteddyfoundation.org.

Incredible Teddy Foundation
Applicant Checklist

Please be sure to include:

- Completed “Grant Application” form (included)
- Completed “Authorization to Release Medical Information” form (included)
- Receipts of purchased items OR vendor invoice
- Demonstration of an attempt to access Teddy’s Home Away from Home Fund if requesting funds for housing at Boston Children’s Hospital.

For assistance with the completion of this application, please see the social worker assigned to your case.

Incredible Teddy Foundation
Grant Application

Personal Information

Patient's Name: _____
Date of Birth (or Due Date): ____/____/_____
Parent/Guardian Name(s): _____
Home Address (city, state, zip): _____
Hospital (including city & state): _____
Daytime phone: _____
Parent/guardian email address: _____
What is the best way to contact you (cell, email, etc.): _____

Health History

Briefly summarize the patient's current health status with regard to CDH and any other diagnoses: _____
_____
_____
_____
_____
_____

Grant Request

In order to receive a grant from the Incredible Teddy Foundation, the organization requires any of the following: receipts, vendor invoice

Please answer the following on a separate page:
1. Indicate how the parent/guardian will meet the requirements for the grant (receipts, vendor invoice).

2. Describe the item(s) for which the family is seeking funding or reimbursement.

3. In what ways will this assist the applicant or his/her immediate family? How is CDH having an impact on the family's life?

4. Have you applied for a grant from the Incredible Teddy Foundation in the past? If so, what is the status of that application?

Grant amount requested: $_____

Parent/Guardian Signature: _____
Parent/Guardian Full Name: _____
Date: _____
Physician Signature: _____
Physician Full Name: _____
Physician Telephone: _____
Date: _____

Incredible Teddy Foundation
Authorization to Release Medical Information

I authorize the named health care provider to release the information specified to the Incredible Teddy Foundation.

Provider Information

Name: _____
Address: _____
_____
Telephone: _____
Fax: _____
Email: _____

Patient: _____

SS#: _____

DOB: _____

RECORDS AUTHORIZED TO BE RELEASED:

CDH DIAGNOSIS

This information will be used for the purpose of verifying my eligibility for services offered by the Incredible Teddy Foundation.

This authorization will expire one year from the date of the signature below.

_____
Patient Date