Cael's Angels Association
Helping Honor Baby Angels

Request for Assistance

To request assistance for a program, please complete this form and upload it and invoices online at www.caelsangels.org. You may also print and return this form, along with copies of invoices for services requested, to Cael's Angels Association 7628 Greenfield Ave. Mounds View, MN 55112 or Email scanned copies to info@caelsangels.org. A representative will contact you within a week. If you require more immediate assistance, please call 763-785-4173.

PART 1: FAMILY INFORMATION

Your Name: _____ Baby's name: _____
Relationship to baby: _____
Address: _____
City, State, Zip: _____
Phone: ( )_____ Fax: ( )_____ Email: _____

PART 2: REFERRAL SOURCE(S)

Referred by (name): _____
Address: _____
City, State, Zip: _____
Phone: ( )_____ Fax: ( )_____ Email: _____
Signature: _____ Date: _____

PART 3: END-OF-LIFE EXPENSES PROGRAM

The End-of-Life Expenses program provides financial assistance to families of stillborn babies with expenses relating to their baby's death.

Expenses
Please check the services below for which you are requesting financial assistance and attach copies of invoices. Payment, if approved, will be sent directly to the service provider and a copy will be sent to you.

1. Autopsy
   a. Hospital/Laboratory:_____ Contact (if known): _____
   b. Address: _____
   c. City, State, Zip:_____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

2. Funeral/Burial
   a. Funeral Home:_____ Director: _____
   b. Address: _____
   c. City, State, Zip:_____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

3. Cremation
   a. Crematorium:_____ Contact (if known): _____
   b. Address: _____
   c. City, State, Zip:_____ Phone: ( ) _____
   d. Financial Need: $_____ ❒ Invoice attached

4. Cemetery Plot & Foundation
    a. Cemetery:_____ Contact (if known): _____
    b. Address: _____
    c. City, State, Zip:_____ Phone: ( ) _____
    d. Financial Need: $_____ ❒ Invoice attached
5. Headstone
    a. Company:_____ Contact: _____
    b. Address: _____
    c. City, State, Zip:_____ Phone: ( ) _____
    d. Financial Need: $_____ ❒ Invoice attached

6. Stationary (birth/death announcements, thank you notes)
    a. Stationer/Printer:_____ Contact: _____
    b. Address: _____
    c. City, State, Zip:_____ Phone: ( ) _____
    d. Financial Need: $_____ ❒ Invoice attached

PART 4: GREIF ASSISTANCE PROGRAM

The Grief Assistance Program provides funding for uninsured and underinsured families pursuing counseling services to work through the grief of stillbirth.

Provider name:_____(circle one): MD/PhD/CSW/MSW
Address: _____
City, State, Zip:_____ Phone: _____
Financial Need: $_____ ❒ Invoice(s) attached

PART 5: ELIGIBILITY & RELEASE

Cael's Angels Association reserves funding for families with the greatest need, and may not provide financial assistance to those who are receiving benefits from another agency.

❒ I am not receiving/do not expect to receive financial assistance from other sources for the expenses indicated on this request for assistance.
❒ I have received/expect to receive the following assistance: _____
_____
_____

I authorize Cael's Angels Association and its representatives to discuss with the providers listed in Parts 3 and 4 of this form, my financial obligations as indicated on the attached invoices.

_____
Signature Date

Medicaid /Social Services
You may be eligible for assistance through Social Services or Medicaid. Please call Medicaid or your county offices for an application. You may also ask your funeral director to help you apply.

Funding for these programs is made possible primarily through donations from families of stillborn babies. Please consider asking your friends and/or family to donate to Cael's Angels Association. You may also add our contact information below to your child's obituary.

Cael's Angels Association
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