

## Zip-IT for FUNDS Foundation Family of Multiples (twins, triplets, etc.) Application

APPLICANT INFORMATION		NAMES OF CHILDREN AND AGES		
Your Name:		Name(s)	Birth Date	Ages
Spouse Name or Name of child's other parent				
Mailing Address (include Suite/Apt#)		Email Address		
City, State, Zip		Home Phone	Work Phone	Cell Phone Number
Your Employer	Spouse's Employer	How did you hear about us?		
Name of Medical Institution to be Paid		Total Cost for Medical Expenses		
MEDICAL PAYMENT POLICY				
<p>If a medical payment is granted, you will be notified via phone or letter. Checks will be made payable directly to the medical institution on behalf of the family. Parents must submit to Zip-IT for FUNDS foundation a statement with the exact name of the medical entity to be paid. Payment amounts are determined based on financial need. A maximum of \$500 can be granted to families who meet the requirements through the medical assistance fund.</p>				
<p>I have included the following documentation with this application:</p> <p><input type="checkbox"/> 1-page letter explaining the medical condition or reasons for your child's extended stay in the hospital or medical facility.</p> <p><input type="checkbox"/> Proof of financial need (Pay stubs, last years tax forms, proof of participation in government funded financial assistance program (WIC, Food Stamps, School Lunches))</p> <p><input type="checkbox"/> A statement from the medical entity listing the entity name and full cost of medical expenses.</p>				

**I accept the above statements and medical policy and requirements.**

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian:

Relationship to child in care:  
Mother or Father (Circle One)

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Complete and mail application to: Zip-IT for FUNDS, Inc.  
106 Jordan Drive ♦ Lizella, Georgia 31052-3322