

Epiphany Caring For Life

Application: Pack and Play or Car Seat

Date: _____
Approved by: _____
Denied for: _____

****Please fill out form COMPLETELY and return to:
Epiphany Caring For Life, 1900 111th Ave. N.W., Coon Rapids, MN 55433,
612/803-2225 or fax 763/862- 4303**

I am interested in a (circle one): **PACK AND PLAY** **CAR SEAT**

Date: _____ How did you hear about Epiphany Caring For Life? _____

Mother's Name: _____ Mother's D.O.B. _____ Age: _____

Address: _____ City: _____ Zip: _____ County: _____

Phone(s): _____ E-mail: _____

Baby's due date or birth date: _____ Baby's gender: Boy or Girl

**FILL IN MONTHLY DOLLAR AMOUNTS (No X,s , dashes, check marks)
IF ZERO PLEASE WRITE IN ZERO**

What money do you have coming in monthly:

Employment \$ _____

General Assistance \$ _____

MFIP \$ _____

Food Support \$ _____

Unemployment \$ _____

Social Security \$ _____

Family support/other income \$ _____

Child Support \$ _____

Total Income: \$ _____

Where do you spend your money every month?

Housing \$ _____ Utilities: \$ _____

Food \$ _____ Diapers: \$ _____

Car payment \$ _____ Car Insurance \$ _____

Gas \$ _____ Medical Insurance \$ _____

Phone \$ _____ Cell: \$ _____

Internet \$ _____ Cable: \$ _____

Credit Card \$ _____ Other Debt \$ _____

Entertainment/clothing/other expenses \$ _____

Total Expense: \$ _____

Race/Ethnicity: African American ____ African American ____ White ____ American Indian ____
Asia/Pacific Islander ____ Mixed/Other _____

Ethnicity: Hispanic ____ Not Hispanic ____

Marital Status: Not Married ____ Married ____ Separated ____ Divorced ____

Number of household members _____ **Number of children** _____ **Ages of children:** _____

Why are you seeking assistance? Have you tried other sources? Please write down any special circumstances or medical conditions?

Epiphany Caring For Life is a non-profit organization which is partially funded by Positive Alternatives Grant. ECL provides assistance to low-income pregnant women. I understand that the approval is subject to the decision of this agency and the availability of items. I authorize any person or agency to release information about my assets or liabilities to this agency for the purposes of confirming my financial need. I certify that the information that I have provided on this application is true.

A limited supply of cribs is available for infants with special medical needs, safety concern, or multiple births. If you require a crib please make a note under "Comments".

****Client Signature:** _____

4/26/16