Care for Your Miracle

Low-Income Discount Request Form

Non-medical postpartum and infant support

This form helps us understand whether your family may qualify for a reduced-rate care block. Information is kept private and used only to review your discount request. Discounts depend on availability and are not guaranteed.

Parent / Guardian Information

Parent/Guardian Name: _____ **Date:** _____

Phone: _____ **Email:** _____

Child/Baby Name: _____ **Baby Age:** _____

Household and Income Information

Number of people in household: _____ **Monthly household income: $** _____

Income type / source: ☐ Employment ☐ Child support ☐ Disability/SSI ☐ Other

Do you currently receive any assistance? Check any that apply:

☐ SNAP/EBT ☐ WIC ☐ Medicaid ☐ Housing assistance ☐ TANF ☐ Other

Optional proof provided: ☐ Yes ☐ No ☐ I can provide if requested

Discount Request

Reason for request / current hardship:

_____

_____

_____

Requested care date(s) or time frame: _____ **Requested discount amount, if known:** _____

☐ I am requesting a reduced hourly rate. ☐ I am requesting help with a care package/block.

Acknowledgment

I understand that submitting this request does not guarantee a discount. I certify that the information I provided is true to the best of my knowledge. I understand Care for Your Miracle may ask for additional information before approving a discount.

Parent/Guardian Signature: _____ **Date:** _____

Office Use Only

☐ Approved ☐ Denied ☐ More information needed

Approved discount/rate: _____ **Reviewed by:** _____ **Date:** _____

Notes: _____