Our Mission:

We believe every child deserves the opportunity to live a full life! Some children need specialized equipment and/or therapy to ensure this happens. Unfortunately, needed services and resources are costly, and too often insurance denies coverage. Therefore, Mariah's Miracle was founded! Our mission is to provide assistance to cover the cost of pediatric patients' needed therapy and equipment when insurance will not. Our vision is that every Arizona child receives the services and resources critical to living a full life!

2024 Application

Child's Name: ____________________________________ Child's Birth Date: _______________

Parent/Guardian Name(s): ____

Address: ____

Street City State Zip Code

E-mail: ____ Phone Number: ________________

What is the purpose of the requested aid? (*Please describe specific equipment, therapy services, etc.)* Attach justification of the child's needs by a medical professional or clinical notes, plus insurance/benefit denial with application.

Amount requested (estimate is OK): ______________________________

Name of Treating Therapist: ______________________________ Phone #: _________________

Have you/a family member/a person in your household received aid from Mariah's Miracle in the past? If yes, please provide the name of the person assisted.

____

How did you hear about Mariah's Miracle? ____

RELEASE

Mariah's Miracles hopes to help as many families in our community as possible. By sharing your story, we will be able to expand our reach within our community. We promise to share your story with the highest integrity, with your permission only. We may request photos, testimonials and/or appearances.

Please initial one of the following:

_____ I/We give Mariah's Miracle consent to use our family's story (without our last name).

_____ I/We do not give Mariah's Miracle consent to use our family's story.

APPLICATION AUTHORIZATION

I/We affirm and agree that:

- I/We have read the guidelines and understand them.
- I/We attest this information is true to the best of my/our ability.
- I/We understand that if approved for assistance, payments may be made on our behalf directly to the equipment provider or clinic.
- I/We understand that Mariah's Miracle is not a HIPAA-covered entity.
- If authorizing the release of our family's story:
  - I/We understand that neither my child nor I/us will receive any compensation because of the use or our information and photos, testimonials or appearances as described in this release. I waive any rights of privacy and/or approval of the materials in which our name and/or likeness may be used.
  - I/We hereby grant Mariah's Miracle permission without restriction to use in all media my family's first names and photos, as well as the story of my child's illness, injury and/or treatment, to promote the purposes of Mariah's Miracle.

Signature: ____ Date: __________________

Submit completed application with supporting documents to info@mariahsmiracle.org or mail to: Mariah's Miracle 14557 W Indian School Rd Ste 500 Goodyear, AZ 85395