Financial Assistance

How We Can Help

Aeron's Foundation provides financial assistance for expenses that bereaved parents face in making final arrangements for their baby who has died. This is made possible due to the generosity of private donations and fundraising efforts.

If you are a bereaved parent or family member seeking assistance with funeral costs, or if you are experiencing financial hardship due to these expenses, please complete the following application. Starred fields must be filled out. **Submitted applications will be reviewed and response will typically be provided within 4 weeks of submission. Please remember to include supplemental documentation, and send us an e-mail in order ensure prompt processing of your application.**

If submitting through postal mail, please send the application to:

Aeron's Foundation
Attention: Financial Assistance
P.O. Box 56061
Sherman Oaks, CA 91413

Financial aid will be granted in the form of Visa gift cards. Aeron's Foundation cannot issue checks directly to the family. Families are eligible to receive financial aid up to one year after the loss of your child. For more information please contact info@aeronsfoundation.org.

Eligibility requirements:

- ✓ Low income household as defined by the Department of Housing and Urban Development (income does not exceed 50% of median income in Los Angeles County).*
- ✓ Child must be 12 months or younger, with undetermined cause of death.

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- ✓ Must be a resident of Los Angeles County.
- ✓ Case must have been submitted to the LA Medical Examiner's Office.

1. Primary Contact Information:

*First Name:_____

*Last Name:_____

*Address:_____

*E-mail:_____

*Phone number:_____

*Relation to child:_____

*Preferred contact method?

- ☐ Phone
- ☐ E-mail
- ☐ Mail

2. Child's Information:

*Child's Full Name:_____

*Child's Gender:_____

*Child's Ethnicity (circle one):

American Indian/Alaska Native	Asian
Black or African American	Hispanic or Latino
Native Hawaiian/Pacific Islander	White
Multiple	Prefer not to answer

*Child's Date of Birth:_____

*Child's Date of Death:_____

Hospital or place of child's birth?_____

*Cause of death?_____

*LA County Medical Examiner-Coroner case number:_____

3. Financial Information

Parent 1	***Parent 2***
*Full Name	Full Name
Birthdate	Birthdate
Ethnicity	Ethnicity
*Address	Address
Phone number	Phone number
Email address	Email address
Marital Status	Marital Status
Occupation	Occupation
Hours of work per week	Hours of work per week
*Average monthly income *(examples: monthly paystub, letter from employer, etc).*	Average monthly Income

*Other sources of monthly income *(examples: social security, alimony, child support, welfare, etc).*	Other sources of income (monthly)
*Combined household monthly income	
Family	
*Number of dependents in family (please list relationship to child, and age)	1. 2. 3. 4. 5. 6. 7. 8.

Any other financial information we should know about? _____

4. Grant request (please attach quotes or bills for documentation):

*Amount requested from Aeron's Foundation (up to $2,000) _____

*Please provide the full name and preferred mailing address of the person who will receive the gift card:

Recipient name _____

Mailing address _____

E-mail address _____

*Please describe how this financial assistance will benefit you and your family:

5. Other:

*How did you hear about Aeron's Foundation? _____

*A certain number of SIDS cases have been attributed to underlying conditions that may not be apparent upon autopsy (such as heart rhythm issues, seizures, etc). Such conditions may be detected through genetic testing and if found may be useful in screening other family members (such as siblings) for their risk of sharing the same condition. Would you like to be contacted for further information about genetic testing for your child?

- ☐ Yes
- ☐ No

If yes, when?

- ☐ 3 months
- ☐ 6 months
- ☐ 12 months

Other questions or comments:_____

6. Supplemental Documentation

Please attach a copy of each of the following with this application

- ☐ Proof of LA County residency (copy of utility bill, copy of official ID, etc).

- ☐ Proof of relationship to child (copy of birth certificate, proof of adoption, etc).
- ☐ Proof of income (letter from employer, paystub, bank statement, annual tax return, etc).

7. Signature Attestation:

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for financial assistance.

I acknowledge that Aeron's Foundation reserves the right to verify the information contained in my application at any time including but not limited to financial information, employment, quotes, and LA County Medical Examiner-Coroner's office case information.

I am aware that all submitted information will be retained for a minimum of 7 years.

_____ _____

Signature of Parent Date

_____

Printed name of Parent

Resources:

*Los Angeles County FY 2025 Low Income Limits (50%) Summary

Persons in family	1	2	3	4	5	6	7	8
Income limit	53,000	60,600	68,150	75,750	81,800	87,850	93,900	100,000

https://www.huduser.gov/portal/datasets/il.html

Los Angeles County Medical Examiner-Coroner Case Search:

https://mec.lacounty.gov/

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