Hope Restored Grant Application

Compassionate Support for Mothers Facing Unplanned Pregnancies

A ministry of By His Hand Foundation

"Daughter, your faith has made you well. Go in peace." — Mark 5:34

By choosing to carry your child despite difficult circumstances, you are demonstrating extraordinary courage, strength, and selflessness. Your decision is an act of hope that deserves to be honored, supported, and celebrated.

The Hope Restored Grant provides financial assistance during pregnancy and after childbirth. Our goal is to lessen your financial burden and surround you with a caring community so you can bring your baby into a beautiful life and a strong family.

Thank you for applying. You may choose to fill out the information with an advocate from Care Net, Antioch Adoptions or a nonprofit of your choice. The information you share will be treated with care and reviewed only by authorized Foundation representatives and members of the Grant Committee.

1. Applicant Information

Family Information

Legal Name _____

Preferred Name _____

Date of Birth _____

Phone Number _____

Email _____

Current Address _____

State _____

Zipcode _____

Are you currently experiencing homelessness or unstable housing?

☐ Yes ☐ No
☐ I prefer to discuss this privately

Preferred method of contact:

☐ Phone call
☐ Text message
☐ Email
☐ Other: _____

Is it safe for us to leave a voicemail?

☐ Yes ☐ No

Is it safe for us to send text messages?

☐ Yes ☐ No

2. Caseworker or Partner Organization

Applicants must work with a representative from a nonprofit organization or government agency of their choice. This may include a social worker, pregnancy resource center advocate, housing caseworker, treatment professional, medical social worker, church care coordinator, or another approved support professional.

Organization or agency name:

Caseworker or support professional's name:

Title or role: _____

Phone number: _____

Email address: _____

How long have you worked with this person or organization?

May By His Hand Foundation contact this person to verify information and coordinate approved assistance?

☐ Yes ☐ No

A signed release may be required before the Foundation discusses personal information with your caseworker.

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3. Pregnancy Information

Estimated due date: _____

How many weeks pregnant are you? _____

Have you received confirmation of your pregnancy from a medical provider?

☐ Yes
☐ No
☐ Appointment scheduled

Name of prenatal care provider or clinic, if applicable:

Date of your next prenatal appointment: _____

Are you currently receiving regular prenatal care?
☐ Yes
☐ No
☐ Not yet, but I would like help finding care

Is this pregnancy considered medically high-risk?
☐ Yes
☐ No
☐ Unsure

Please briefly explain any medical concerns or pregnancy-related needs you would like us to understand:

_____

_____

_____

Do you intend to carry this pregnancy to term?

☐ Yes ☐ No
The Hope Restored Grant is intended for applicants who plan to continue their pregnancies. Applicants who later elect to terminate their pregnancies will no longer be eligible for unpaid grant installments or future awards from this program.

A miscarriage, stillbirth, medical emergency, or other involuntary pregnancy loss does not result in automatic ineligibility.

_____

4. Household Information

Current marital or relationship status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Other: _____

Who currently lives in your household?
Name Age Relationship

How many children do you currently parent or financially support? _____

Are any of your children currently living outside your home?

☐ Yes ☐ No Please explain only what you are comfortable sharing:

_____

_____

Do you currently have a safe and stable place to live?

☐ Yes
☐ No
☐ Temporarily
☐ Unsure

Are you currently at risk of eviction, utility shutoff, or losing your housing?

☐ Yes
☐ No
☐ Unsure

Please explain:

_____

_____

_____

5. Requested Assistance

Please select the types of assistance you are requesting.

During Pregnancy

☐ Rent & Utilities assistance
☐ Groceries or household essentials
☐ Transportation
☐ Prenatal medical expenses or copays
☐ Maternity clothing
☐ Pregnancy-related supplies
☐ Counseling or mental health support
☐ Employment assistance
☐ Educational assistance
☐ Temporary housing
☐ Other: _____

After Delivery

☐ Diapers or infant supplies
☐ Formula or breastfeeding supplies
☐ Postpartum medical expenses
☐ Counseling or emotional support
☐ Rent or housing stabilization
☐ Utility assistance
☐ Transportation
☐ Childcare assistance
☐ Employment assistance
☐ Educational assistance
☐ Other: _____

Current Priority Needs

Please list your three most urgent needs.

1. _____

Estimated cost: $_____
Payment due date: _____

2. _____

Estimated cost: $_____
Payment due date: _____

3. _____

Estimated cost: $_____
Payment due date: _____

Total amount requested: $_____

Please explain how this assistance would help you during your pregnancy or after delivery:

_____

_____

_____

Whenever possible, the Foundation may pay landlords, utility providers, medical providers, counselors, retailers, or other approved vendors directly.

_____

6. Support System

Do you currently have family members or friends who provide practical or emotional support?

☐ Yes
☐ No
☐ Limited support

Please describe your current support system:

_____

_____

Are you connected with a church, pregnancy center, social service organization, treatment provider, shelter, or community program?

☐ Yes ☐ No

Organization name: _____

Contact person: _____

Phone or email: _____

Would you be interested in connecting with a circle of women who would like to support you during pregnancy and after your baby is born?

This support may include practical care, such as meals, light housekeeping, childcare, or respite care, as well as friendship, encouragement, and opportunities to connect with a caring community.

☐ Yes ☐ No

_____

7. Personal Circumstances and Support Needs

The following questions help us understand how to support you. Substance use, addiction, mental health challenges, homelessness, incarceration, or other hardships do not automatically disqualify you.

Please select any circumstances that currently affect you:

☐ Housing instability
☐ Domestic violence or safety concerns
☐ Substance use or addiction
☐ Recovery or treatment needs
☐ Mental health challenges
☐ Physical health concerns
☐ Recent incarceration
☐ Transportation difficulties
☐ Unemployment
☐ Lack of family support
☐ Immigration-related challenges
☐ Parenting concerns
☐ Other: _____
☐ I prefer to discuss this privately

Would you like help connecting with any of the following?

☐ Prenatal care
☐ Substance-use treatment
☐ Mental health counseling
☐ Domestic violence services
☐ Safe housing
☐ Food assistance
☐ Transportation
☐ Parenting education
☐ Legal assistance
☐ Adoption counseling
☐ Other: _____
☐ Not at this time

Please share anything else that would help us understand your circumstances:

_____

_____

_____

_____

8. For Applicants Considering Adoption

By His Hand Foundation does not provide adoption placement services and will not select an agency or adoptive family for you. If you choose adoption, the Foundation requires that the adoption be facilitated through a licensed nonprofit adoption agency.

Are you currently working with an adoption agency?

☐ No
☐ Yes

Agency name: _____

Agency contact: _____

Phone or email: _____

Is the agency a licensed nonprofit organization? ☐ Yes ☐ No ☐ Unsure

Applicants considering adoption are encouraged to receive independent counseling and legal advice. Accepting this grant does not obligate you to place your child for adoption, work with a particular family, or continue an adoption plan.

9. Applicant Statement

Please tell us about yourself, your pregnancy, and what you hope life will look like for you and your baby after delivery.

10. Applicant Responsibilities

By accepting assistance through the Hope Restored Grant, I agree to:

- Maintain regular communication with my caseworker during pregnancy and through the grant period.
- Notify the Foundation of significant changes in my contact information, housing, pregnancy status, financial circumstances, or requested expenses.
- Use grant funds only for approved pregnancy or postpartum expenses.
- Provide receipts, invoices, or other documentation when requested.
- Provide truthful and complete information.
- Treat Foundation staff, volunteers, caseworkers, and partner organizations with honesty and respect.
- Notify the Foundation if I begin pursuing an adoption plan so that appropriate nonprofit resources and support can be offered.
- Understand that funding may be delayed, reduced, or discontinued if I provide false information, misuse grant funds, no longer meet eligibility requirements, or become unreachable despite reasonable attempts to contact me.

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11. Applicant Acknowledgments

Please initial each statement.

_____ I understand that submitting an application does not guarantee an award.

_____ I understand that awards depend on eligibility, documented need, available funding, and approval by the Grant Committee.

_____ I understand that the grant is generally provided in two installments: one during pregnancy and one after delivery.

_____ I understand that the Foundation may pay approved expenses directly to vendors or service providers.

_____ I understand that I am not required or expected to choose adoption.

_____ I understand that the Foundation will not pressure me to parent or place my child for adoption.

_____ I understand that if I choose adoption, I must work with a licensed nonprofit adoption agency to remain eligible for adoption-related assistance.

_____ I understand that substance use, addiction, mental health challenges, homelessness, incarceration, or financial hardship do not automatically disqualify me.

_____ I understand that if I elect to terminate my pregnancy through abortion, I will become ineligible for unpaid installments and future Hope Restored Grant awards.

_____ I understand that funds properly distributed and used for approved expenses generally do not have to be repaid. Funds obtained through fraud, misrepresentation, or intentional misuse may be subject to repayment or other action permitted by law.

_____ I understand that miscarriage, stillbirth, or another involuntary pregnancy loss does not automatically end my eligibility for compassionate assistance.

_____ I understand that By His Hand Foundation is not an adoption agency, medical provider, mental health provider, legal office, emergency shelter, or government child-welfare agency.

_____ I understand that the Foundation may be legally required to report certain disclosures involving suspected child abuse, neglect, exploitation, immediate danger, or threats of serious harm.

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12. Permission to Verify Information

I authorize By His Hand Foundation to verify information contained in this application with the caseworker, nonprofit organization, or government agency identified by me, as reasonably necessary to evaluate or administer the grant.

Applicant initials: _____

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13. Certification and Signature

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that intentionally false or misleading information may result in denial, suspension, or termination of assistance.

Applicant signature: _____

Printed name: _____

Date: _____
