 Child's Full Name _____

Northern Nevada Children's Cancer Foundation

3550 Barron Way, #9A, Reno, NV 89511
Phone 775.825.0888 Fax 775.825.4726
Web www.NvChildrensCancer.org
Email Brigette@NvChildrensCancer.org

Our mission is to enhance the quality of life for children with cancer and their families by providing financial assistance and compassionate support programs while advocating for increased research funds and raising public awareness.

INSTRUCTIONS FOR FINANCIAL ASSISTANCE

Please complete the attached application and return it to the NNCCF office by fax, email or mail; the addresses are listed above. You will be contacted by a staff member when it has been received.

PATIENT INFORMATION							
Patient's Name					Male		Female
Birth Date	Month	Day	Year	Age at diagnosis			
Patient's Interests & Hobbies							

GUARDIAN INFORMATION							
Parent/Guardian's Name (s)							
Marital status of Parents/Guardians							
If divorced, please provide name of custodial parent							
Street Address							
City		State		Zip			
Home Phone		Work Phone	Name				
Cell Phone	Name		Cell Phone	Name			
E-Mail(s)							
Places of employment of Parents/Guardians							

Initial _____ Date _____

Child's Full Name _____

HOUSEHOLD INFORMATION

Primary Language Spoken			
# Of Adults Residing In Household		# Of Children Residing In Household	
Siblings Names, Ages, Interests & Hobbies			

MEDICAL INFORMATION

Please provide all information as accurately as possible

Diagnosed Illness				Date Diagnosed	
Primary Oncologist				Treatment Facility	
Phone	Area Code		Fax	Area Code	
Social Worker's Name				Email	
Phone	Area Code		Fax	Area Code	

INSURANCE INFORMATION

Is patient covered by private insurance? (Check one)	Yes	No
If "yes" insurance name:		
Is patient covered by a state funded insurance plan i.e. Medicaid? (Check one)	Yes	No
If applicable, have you completed an application for Medicaid? (Check one)	Yes	No

OTHER INFORMATION

How did you hear about NNCCF?	
What other assistance have you applied for or received at this time?	

Use the space below to describe medical and non-medical expenses that a grant of financial assistance could help alleviate (e.g., utility bills, transportation, etc.). Please list most urgent needs first and attach additional sheet if necessary.

PLEASE CAREFULLY READ THE FOLLOWING INFORMATION

- NNCCF does not discriminate against or deny aid because of your race, religion, color, national origin, sex, political affiliation or any other protected category under state or federal law.
- Your application will be reviewed on a case-by-case basis. A final determination for financial assistance is subject to availability of funds and adherence to NNCCF guidelines.
- The information provided to NNCCF will be used solely for the purpose for which it was provided and will be kept confidential.
- NNCCF does not have any agreements with medical providers to refer patients to providers, nor would NNCCF be willing to enter into any such agreement. NNCCF cannot and will not provide advice to our clients concerning (1) what treatment to pursue; (2) from which medical providers to seek treatment; (3) insurance coverage for treatments prescribed and/or received; or (4) any other decision affecting the health and/or medical treatment of our clients. NNCCF encourages all clients to conduct their own research as to appropriate pediatric oncology treatment, and to make their own decisions concerning these issues.
- NNCCF cannot and will not provide tax or legal advice.

GENERAL RELEASE OF LIABILITY AUTHORIZATION FOR RELEASE AND USE OF MEDICAL RECORDS AND MEDIA CONSENT

The undersigned ("Releasor") has requested assistance from Northern Nevada Children's Cancer Foundation ("NNCCF"), a non-profit charitable organization. In making such request, Releasor understands and acknowledges that the granting of assistance is entirely discretionary and that NNCCF may deny such assistance at any time for any reason. Releasor hereby agrees to waive any and all claims against NNCCF and release NNCCF from any and all liability which may arise from NNCCF's conduct in consideration of this Application for Assistance.

Releasor consents to and authorizes the release and use of *Protected Health Information*, which may be protected under federal law, from all medical care facilities, insurance groups and/or social welfare agencies to NNCCF. Releasor further authorizes NNCCF personnel to speak directly with patient's medical providers and/or social workers. Releasor authorizes NNCCF to release and utilize patient's medical information as it relates to NNCCF's non-profit activities. If Releasor is 18 years of age, or upon turning 18 years of age, Releasor authorizes NNCCF to speak with and release information regarding the services provided by NNCCF to Releasor's spouse, parents, guardian, and/or other individual(s) listed below. Releasor acknowledges that this release will remain valid and in place unless and until revoked by Releasor in writing.

Name:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____

Releasor consents to the dissemination and use of the patient's name, likeness, and recorded voice singularly or in conjunction with other photographs and/or recording by the print, television, and radio media, for the purposes of pediatric cancer awareness and for raising funds to further the goals of NNCCF ("media consent"). Releasor acknowledges that s/he has the right to revoke this media consent at any time in writing signed by Releasor. The revocation will only be effective upon receipt by NNCCF.

Signature			
Printed Name		Date	/ /
Relationship to Child			
Dates of Service	Please state approximate date of service beginning on / / - TBD		