



3550 Barron Way, #9A, Reno, NV 89511
 Phone 775.825.0888 Fax 775.825.4726
 Web www.NvChildrensCancer.org
 Email Holly@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	<input type="checkbox"/>	Female	<input type="checkbox"/>
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					Cell Phone					
							Name			
E-Mail(s)										
Places of employment of Parents/Guardians										

HOUSEHOLD INFORMATION					
Primary Language Spoken					
# Of Adults Residing In Household			# Of Children Residing In Household		
Siblings Names, Ages, Interests & Hobbies					
MEDICAL INFORMATION <i>Please provide all information as accurately as possible</i>					
Diagnosed Illness				Date Diagnosed	
Primary Oncologist				Treatment Facility	
Phone			Fax		
	Area Code			Area Code	
Social Worker's Name				Email	
Phone			Fax		
	Area Code			Area Code	
INSURANCE INFORMATION					
Is patient covered by private insurance? (Check one)			Yes	<input type="checkbox"/>	No
If "yes" insurance name:					
Is patient covered by a state funded insurance plan i.e. Medicaid? (Check one)			Yes	<input type="checkbox"/>	No
If applicable, have you completed an application for Medicaid? (Check one)			Yes	<input type="checkbox"/>	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		