Jason's Friends Foundation

340 West B Street, Suite 101, Casper, WY 82601
Office: (307) 235-3421 Fax: (307) 265-4668

FAMILY ENROLLMENT REQUEST

TODAY'S DATE: _____

ALL QUALIFYING REQUIREMENTS MUST BE MET TO APPLY:

1. Child's Age cannot exceed 20 years of age
2. Child's Diagnosis must be a brain tumor, spinal cord tumor or childhood cancer
3. Custodial Parent/Guardian must be a US Citizen
4. Custodial Parent/Guardian must be a Wyoming Resident
5. Custodial Parent/Guardian must provide a Wyoming Driver's License

FAMILY INFORMATION:

- CHILD'S FULL NAME: _____
- CHILD'S DATE OF BIRTH: _____ CHILD'S CURRENT AGE _____
  *MUST BE WITHIN AGES OF BIRTH AND 20 YEARS, INELIGIBLE AT 21 YEARS OLD
- CHILD'S SCHOOL: _____ GRADE: _____
- WHERE AND WITH WHOM DOES THE CHILD RESIDE?
  _____
- CHILD'S DIAGNOSIS: _____
  *DIAGNOSIS MUST BE A BRAIN OR SPINAL CORD TUMOR OR CHILDHOOD CANCER
- DATE OF DIAGNOSIS: _____
- HOSPITAL SOCIAL WORKER ASSIGNED TO FAMILY: _____
- CHILD'S DOCTOR: _____
- MEDICAL TREATMENT CENTER: _____

* INDICATES QUALIFYING CRITERIA

- MOTHER'S NAME: _____
- FATHER'S NAME: _____
- STEP-PARENT'S NAME: _____
- MAILING ADDRESS: _____

  (CITY)_____, WY (ZIP) _____
- PHYSICAL ADDRESS: _____

  (CITY)_____, WY (ZIP) _____
- OTHER FAMILY MEMBERS RESIDING WITH YOU--NAMES & AGES:

_____

- ARE YOU AN U.S. CITIZEN? YES_____ NO_____
  *IF NO, YOU ARE NOT ELIGIBLE FOR OUR PROGRAM
- *WYOMING RESIDENCY REQUIRED: HOW LONG IN WYOMING? _____
- *COPY OF WYOMING DRIVER'S LICENSE REQUIRED: LICENSE #_____
- WYOMING COUNTY: _____
- HOME PHONE: _____
- CELL PHONE: _____
- EMAIL ADDRESS: _____

EMPLOYMENT INFORMATION:

Income is not a qualifier. The information requested is to help us understand your financial income level prior to your child's diagnosis compared to what your income level is now.

- MOTHER'S/STEP-PARENT'S EMPLOYMENT PRIOR TO DIAGNOSIS:
  HOW LONG:_____ EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____
- MOTHER'S/STEP-PARENT'S PRESENT EMPLOYMENT:
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____
  EMPLOYER'S PHONE: _____

* INDICATES QUALIFYING CRITERIA

- FATHER'S/STEP-PARENT'S EMPLOYMENT PRIOR TO DIAGNOSIS:
  HOW LONG: _____ EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____

- FATHER'S/STEP-PARENT'S PRESENT EMPLOYMENT:
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____
  EMPLOYER'S PHONE: _____

- WHO WILL MISS WORK TO CARE FOR THE CHILD AND TAKE THE CHILD TO TREATMENTS AND APPOINTMENTS? APPROXIMATELY HOW MUCH INCOME DO YOU EXPECT TO LOSE MONTHLY?
  _____

- IS YOUR FAMILY RECEIVING ANY OTHER TYPES OF ASSISTANCE FROM OTHER AGENCIES, SUCH AS, YOUR HOSPITAL, CHILDREN'S HEALTH SERVICES, KID CARE, SSI, FOOD STAMPS, WIC, MEDICAID, WY HOUSING AUTHORITY? IF SO, HOW MUCH AND WHAT TYPE OF ASSISTANCE IS BEING PROVIDED? _____
  _____

- SHOULD ANY ADDITIONAL ASSISTANCE BECOME AVAILABLE TO YOU, IT IS YOUR RESPONSIBILITY TO INFORM JFF IMMEDIATELY, AS WE CANNOT DUPLICATE SERVICES. INITIALS:_____

- DO YOU HAVE MEDICAL INSURANCE?_____ ANNUAL DEDUCTIBLE:_____

- DO YOU HAVE SICK LEAVE AND VACATION PAY? ____HOW MUCH IS AVAILABLE TO USE TOWARD ABENSENCES FROM WORK? _____

WHAT CAN WE DO TO HELP?

- _____TRAVEL EXPENSES (INCLUDES LODGING, FUEL, FOOD)
- _____MORTGAGE/RENT $_____PER MONTH
- *_____CAR PAYMENT $_____PER MONTH—YEAR/MAKE/MILEAGE:_____
- _____UTILITIES $_____PER MONTH
- _____OTHER HOUSEHOLD BILLS, PLEASE LIST WITH COST

*This would only be the vehicle that is used to take to child to treatments and appointments

ADDITIONAL INFORMATION AND COMMENTS REGARDING YOUR CHILD AND YOUR FAMILY, INCLUDING YOUR CHILD'S HOBBIES AND INTERESTS:_____

_____

SIGNATURE REQUIRED
I CERTIFY THIS TO BE ACCURATE TO THE BEST OF MY KNOWLEDGE.

BY: _____ BY: _____

* INDICATES QUALIFYING CRITERIA

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY (FORM REVISED 11/2014)

DATE RECEIVED: _____

DATE ENROLLMENT APPROVED: _____

*** INDICATES QUALIFYING CRITERIA**