Jason's Friends Foundation

340 West B Street, Suite 101, Casper, WY 82601
Office: (307) 235-3421 Fax: (307) 265-4668
Email: info@jasonsfriends.org Website: jasonsfriends.org

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: ____ GENDER: ☐ M ☐ F
- CHILD'S SCHOOL: _____ GRADE: _____
- WHERE AND WITH WHOM DOES THE CHILD RESIDE?

  _____
- CHILD'S DIAGNOSIS: _____
- DATE OF DIAGNOSIS: _____
- HOSPITAL SOCIAL WORKER ASSIGNED TO FAMILY: _____
- CHILD'S DOCTOR: _____
- MEDICAL TREATMENT CENTER: _____
- ADDITIONAL INFORMATION AND COMMENTS REGARDING YOUR CHILD AND FAMILY, INCLUDING YOUR CHILD'S HOBBIES AND INTERESTS:

  _____

  _____

- MOTHER'S NAME: _____
- FATHER'S NAME: _____
- STEP-PARENT 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 _____
- CAN YOU PROVIDE A U.S. PASSPORT OR U.S. BIRTH CERTIFICATE? YES _____ NO _____
- WYOMING RESIDENCY REQUIRED: HOW LONG IN WYOMING? _____
- DRIVER'S LICENSE NUMBER: _____ **COPY OF WYOMING DRIVER'S LICENSE IS REQUIRED TO SEND IN WITH ENROLLMENT REQUEST
- WYOMING COUNTY: _____
- HOME PHONE: _____
- CELL PHONE (BOTH PARENTS): _____
- EMAIL ADDRESS (BOTH PARENTS): _____

EMPLOYMENT INFORMATION: INCOME IS NOT A QUALIFIER FOR OUR PROGRAM

The information requested is to help us understand your financial income level prior to your child's diagnosis compared to what your income level will be.

- MOTHER'S/STEP-PARENT'S PRESENT EMPLOYMENT:

  EMPLOYER'S NAME: _____

  MONTHLY INCOME: _____

  EMPLOYER'S PHONE:_____
- 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, 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, AS WE CANNOT DUPLICATE SERVICES. INITIALS: _____

- DO YOU HAVE MEDICAL INSURANCE? YES _____ NO _____ ANNUAL DEDUCTIBLE: _____

- DO YOU HAVE SICK LEAVE AND VACATION PAY? YES _____ NO _____

  HOW MUCH IS AVAILABLE TO USE TOWARD ABSENCES FROM WORK?

  _____

HOW CAN WE 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

  _____

****SIGNATURES REQUIRED****
I CERTIFY THIS REQUEST TO BE ACCURATE TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY

DATE RECEIVED: _____

ENROLLMENT APPROVED: YES _____ NO _____

DATE ENROLLMENT APPROVED: _____ APPROVERS INITALS: _____

(FORM REVISED 07/2019)

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Authorization to Release Information

This form is used to release your child's health information as required by federal and state laws. Your authorization allows your child's doctor and hospital to release your child's protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to your child's doctor and hospital. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Name of Child: _____DOB: _____

Address: _____

As Parent/Guardian of (child's name) _____, I authorize

(doctor's name) _____

(address) _____

AND

(hospital's name) _____

(address) _____

to release my child's protected health information to JASON'S FRIENDS FOUNDATION. The information to be released consists of the **diagnosis, schedule and course of treatment** in order to determine eligibility and the extent of support to be received in the Jason's Friends Foundation program.

This authorization will expire when I revoke this authorization by notifying both the doctor and hospital listed above.

By signing below, I authorize the release of my child's protected health information as described above.

Parent/Guardian Name: (print name) _____

Parent/Guardian Name: (print name) _____

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____

Jason's Friends Foundation

AGREEMENT

FINANCIAL SUPPORT:

This agreement is set forth by Jason's Friends Foundation and is between the parties signed below. The family is being supported and financially assisted by Jason's Friends Foundation for non-medical expenses. These expenses might include travel, such as, fuel, lodging and meals/groceries while traveling out of your home town for treatments and appointments. Additionally, Jason's Friends' assistance might include help with essential household bills, such as, the mortgage/rent, utilities, phone, car payments as well as everyday expenses, such as, groceries while the child is in treatment. All expense payment requests are subject to approval. Non-essential items or expenses are paid at Jason's Friends' discretion.

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE: _____

JASON'S FRIENDS FOUNDATION: _____

RELEASE AUTHORIZATION

As Parent/Guardian of _____, I give permission for Jason's Friends Foundation to use my child's first name only, hometown and photo (please provide picture) for the purpose of informing the public about the assistance available. Publication will be through various media sources and during the annual Bowl for Jason's Friends fundraiser.

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE: _____

JASON'S FRIENDS FOUNDATION: _____