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: ____
- MAILING ADDRESS: ____________________________ (CITY)____________, WY (ZIP) _______
- PHYSICAL ADDRESS: ___________________________ (CITY)_____________, WY (ZIP) _______
- CHILD'S DATE OF BIRTH:____________ CHILD'S CURRENT AGE: _____ GENDER: ☐ M ☐ F
- CHILD'S SCHOOL: ____ GRADE: ___________
- CHILD'S DIAGNOSIS: ______________________________ DATE OF DIAGNOSIS: _________
- MEDICAL TREATMENT CENTER: ____
- CHILD'S DOCTOR:____________________ HOSPITAL SOCIAL WORKER: ____________________
- WHERE AND WITH WHOM DOES THE CHILD RESIDE? PLEASE INCLUDE ALL SIBLINGS (NAMES & AGES) AND ANY OTHER FAMILY MEMBERS:

____

____

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

  ____

  ____

- MOTHER'S NAME: ________________________ INVOLVED IN CHILD'S LIFE: YES ___ NO ___
- FATHER'S NAME: _________________________ INVOLVED IN CHILD'S LIFE: YES ___ NO ___
- STEP-PARENT NAME (IF APPLICABLE): ___________ INVOLVED IN CHILD'S LIFE: YES ___ NO ___
- STEP-PARENT NAME (IF APPLICABLE): ___________ INVOLVED IN CHILD'S LIFE: YES ___ NO ___
- MOTHER'S PHONE: ______________ FATHER'S PHONE: ______________ OTHER: ____________
- MOTHER'S EMAIL: ________________________ FATHER'S EMAIL: ________________________
- ARE YOU A U.S. CITIZEN? YES ____ NO ____
- DO YOU HAVE A U.S. PASSPORT OR BIRTH CERTIFICATE? YES _____ NO _____
- WYOMING RESIDENCY: HOW LONG HAVE YOU LIVED IN WYOMING? ____________________

  **COPY OF WYOMING DRIVER'S LICENSE IS REQUIRED TO SEND IN WITH ENROLLMENT REQUEST

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-MOTHER'S PRESENT EMPLOYMENT:

EMPLOYER'S NAME: ____

EMPLOYER'S PHONE: ____

EMPLOYED SINCE: ____

MONTHLY INCOME: ____

FATHER'S/STEP-FATHER'S PRESENT EMPLOYMENT:

EMPLOYER'S NAME: ____

EMPLOYER'S PHONE: ____

EMPLOYED SINCE: ____

MONTHLY INCOME: ____

- 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, FOUNDATIONS OR FUNDRAISERS SUCH AS, YOUR HOSPITAL, CHILDREN'S HEALTH SERVICES, KID CARE, SSI, WIC, MEDICAID, WY HOUSING AUTHORITY, GO FUND ME? IF SO, HOW MUCH AND WHAT TYPE OF ASSISTANCE IS BEING PROVIDED?

  ____

  ____

- SHOULD ANY FURTHER ASSISTANCE BECOME AVAILABLE TO YOU, IT IS YOUR RESPONSIBILITY TO INFORM JASON'S FRIENDS, AS WE CANNOT DUPLICATE SERVICES. INITIALS: _________________
- DO YOU HAVE MEDICAL INSURANCE? YES _____ NO _____
- CHILD'S INDIVIDUAL 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: ___________________________

  ____

PARENTS/GUARDIANS 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: __________

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

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) ____

(Hospital) ____

(Hospital 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 Signature: _______________________________Date: ______________

Parent/Guardian Name: (print name) ____

Parent/Guardian Signature: _______________________________Date: ______________

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 at Jason's Friends Foundation's discretion. Expenses might include, but are not limited to, travel, fuel, lodging and meals/groceries while traveling for treatments and appointments. Additionally, Jason's Friends' assistance may include help with essential household bills, such as, mortgage/rent, utilities, phone, car payments and everyday expenses, such as, groceries while the child is in treatment as well as payments made towards the child's individual medical insurance deductible. All expense payment requests are subject to approval and are paid at Jason's Friends' discretion.

DATE: ____________

PARENT/GUARDIAN PRINTED NAME: ____

SIGNATURE: ____

PARENT/GUARDIAN PRINTED NAME: ____

SIGNATURE: ____

JASON'S FRIENDS FOUNDATION SIGNATURE: ________________________________

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 PRINTED NAME: ____

SIGNATURE: ____

PARENT/GUARDIAN PRINTED NAME: ____

SIGNATURE: ____

JASON'S FRIENDS FOUNDATION SIGNATURE: ________________________________