Jason's Friends Foundation

1701 East E Street, Suite 100, Casper, WY 82601
Office: (307) 235-3421 info@jasonsfriends.org

AGE 18+ PATIENT 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. Child must be a US Citizen
4. Child must be a Wyoming Resident
5. Child must provide a Wyoming Driver's License or State Issued ID Card
6. If 18+ child is being supported by a parent/guardian, the family member will need to complete the Family Enrollment Request Form

FAMILY INFORMATION:

- OF AGE CHILD'S FULL NAME: _____
- SPOUSE'S NAME (If applicable): _____
- HOME PHONE: _____ CELL PHONE: _____
- EMAIL ADDRESS: _____
- MAILING ADDRESS: _____ (CITY)_____, WY (ZIP) _____
- PHYSICAL ADDRESS: _____ (CITY)_____, WY (ZIP) _____
- OF AGE CHILD'S DATE OF BIRTH: _____ CHILD'S CURRENT AGE: ____ GENDER: ☐ M ☐ F
- OF AGE CHILD'S SCHOOL: _____ GRADE: _____
- WHERE AND WITH WHOM DOES THE OF AGE CHILD RESIDE? PLEASE INCLUDE ALL SIBLINGS (NAMES & AGES) AND ANY OTHER FAMILY MEMBERS:
  _____
- OF AGE CHILD'S DIAGNOSIS: _____ DATE OF DIAGNOSIS: _____
- OF AGE CHILD'S DOCTOR:_____ HOSPITAL SOCIAL WORKER: _____

- **MEDICAL TREATMENT CENTER:** _____

- **ARE YOU AN U.S. CITIZEN? 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. 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.

- **PATIENT'S EMPLOYMENT PRIOR TO DIAGNOSIS:** _____**HOW LONG:**_____
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____

- **PATIENT'S PRESENT EMPLOYMENT:**
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____
  EMPLOYER'S PHONE: _____

- **SPOUSE'S EMPLOYMENT PRIOR TO DIAGNOSIS (If applicable): HOW LONG:** _____
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____

- **SPOUSE'S PRESENT EMPLOYMENT (If applicable):**
  EMPLOYER'S NAME: _____
  MONTHLY INCOME: _____
  EMPLOYER'S PHONE: _____

- **WHO WILL MISS WORK TO CARE FOR THE PATIENT AND TAKE THE PATIENT 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?** _____

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: _____

  _____

ADDITIONAL INFORMATION AND COMMENTS REGARDING THE PATIENT INCLUDING HOBBIES AND INTERESTS:

_____

_____

_____

_____

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

BY: _____ BY: _____

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY (FORM REVISED 03/2025)

DATE RECEIVED: _____

ENROLLMENT APPROVED: YES _____ NO _____

DATE ENROLLMENT APPROVED: _____ APPROVERS INITALS: _____

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Authorization to Release Information

This form is used to release your protected health information as required by federal and state laws. Your authorization allows your parent(s) or guardian(s) listed below to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by written request to the parties listed below. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Name of Patient: _____DOB: _____
Address: _____
_____ Phone: ( ) _____

As Patient, _____, I authorize

(Patient's Parent/Guardian)_____
(address) _____

AND

(Patient's Parent/Guardian) _____
(address) _____

to release my protected health information to JASON'S FRIENDS FOUNDATION, 1701 East E Street, Suite 100, Casper, WY 82601.

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 parents listed above.

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

Patient's Name: (print name) _____

Patient's 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: _____

PATIENT'S SIGNATURE: _____

JASON'S FRIENDS FOUNDATION: _____

RELEASE AUTHORIZATION

I,_____, give permission for Jason's Friends Foundation to use my 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: _____

PATIENT'S SIGNATURE: _____

JASON'S FRIENDS FOUNDATION: _____