APPLICATION FOR FINANCIAL ASSISTANCE

Up to $3000 Award

children's cancer family foundation
OF NORTHEAST WISCONSIN
granting support | embracing families | building connections

Child's Information

Name: _____

Date of birth: _____ Gender: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Family Information

PARENT/GUARDIAN 1

Name: _____

Address: ❑ Same as above _____

City: _____ County: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Best time to call: _____ Email: _____

PARENT/GUARDIAN 2

Name: _____

Address: ❑ Same as above _____

City: _____ County: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Best time to call: _____ Email: _____

SIBLING(S)

Name(s) and age(s): _____

Medical Information

Child's diagnosis: _____

Date of diagnosis: _____/_____/_____ Child's physician: _____

Hospital name: _____

Hospital full address:_____

Social worker name: _____

Social worker direct phone and extension: _____

Personal and Financial Information

How did you hear about CCFF? _____

Marital status: _____Race:_____

How many people live in your household? _____ How many parents are employed? _____

Do you have health insurance? ❑ Yes ❑ No

Where do you get your insurance*? ❑ Employer ❑ Marketplace or exchange ❑ Individual ❑ Private

❑ Medicare ❑ Medicaid ❑BadgerCare

What is your deductible per person? _____ Per family? _____

What is your out-of-pocket maximum per person? _____ Per family? _____

**If you don't know your insurance information, you can send us your SBC (Summary of Benefits and Coverage).*

Total gross income (before taxes) for family: _____

What type of bills are you asking us to help with (medical, travel, utilities, mortgage, rent, education assistance, etc) _____

_____

Total amount you are requesting: _____

Please note that the maximum grant is $3000 per family per calendar year. CCFF's grants of financial assistance is restricted to residents of Northeastern Wisconsin.

Please tell as about your family's pediatric cancer journey so we can get to know you better — share a little about yourself, your family, and your most immediate needs so we can best understand how a financial grant from CCFF would benefit you.

If you are requesting funding for medical, travel, or living expenses due to your child's cancer treatment, we require a letter from the physician or social worker indicating the diagnosis type, your most recent Explanation of Benefits (EOB) from your insurance carrier, the Summary of Benefits and Coverage (SBC) if you don't know your plan's deductible/out of pocket maximum.

If you are requesting a grant for educational assistance like private tutoring or devices to help your child in the classroom that aren't available through his or her school, please also include a letter from your child's teacher or principal stating the need for the additional resource. Please ensure the letter includes the teacher or principal's contact information. If requesting assistance for tutoring, please include invoices from the tutor. Tutoring services must come from a licensed educator in the state of Wisconsin and/or a certified clinician/educational specialist. The letter must include the tutor's or clinic's credentials. Feel free to contact us if you have any questions.

Medical Release

❑ **I understand and grant my permission to all my child's doctors, social workers, clinics and hospitals to release all healthcare and billing information relating to my treatment and care for my child's cancer and other related health problems to Children's Cancer Family Foundation of Northeast Wisconsin, Inc. I also grant my permission for my child's medical care and educational team to discuss the above information with any designated representative of Children's Cancer Family Foundation of Northeast Wisconsin, Inc by phone.**

I authorize the release of requested healthcare and billing information to Children's Cancer Family Foundation of Northeast Wisconsin, Inc. The purpose of my request is to assist Children's Cancer Family Foundation of Northeast Wisconsin, Inc in determining my eligibility for financial assistance. Children's Cancer Family Foundation of Northeast Wisconsin, Inc will not disseminate or release these medical records to any outside source without first obtaining prior express consent. I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by Children's Cancer Family Foundation of Northeast Wisconsin, Inc. I also understand that there is a limit to the assistance I may receive. I understand and agree that no promises nor assurances whatsoever have been made to me by any representatives of Children's Cancer Family Foundation of Northeast Wisconsin, Inc regarding the assistance I am requesting.

By signing this application, you are attesting to the accuracy of the information on all pages, to the best of your knowledge. Fraudulent applications may result in your institution being deemed ineligible for this program. Please be sure that the entire application is complete before submitting. Incomplete applications will be returned.

Child's name: _____

Parent/guardian Signature: _____ Date: _____

Publicity Release

❑ **Children's Cancer Family Foundation of Northeast Wisconsin, Inc may hold events and fundraisers throughout the year to raise money to fund the primary objective of the foundation: to provide financial assistance to families battling pediatric cancer. People continue to support us because they want to see their money find its way to the people who need it the most. We need your help to put a face and a name to that reality. By checking the box, you are stating that you agree we can use you and your child's photo, names, and your submitted story. If your application is approved, Children's Cancer Family Foundation of Northeast Wisconsin, Inc may also use a brief description of how the assistance that you received has helped your family. This will facilitate communication with our donors and help in attracting more contributors. Please acknowledge this notice-release by checking the box above and signing the application. I hereby acknowledge that Children's Cancer Family Foundation of Northeast Wisconsin, Inc may use my and my child's name, photo, background and story in PR and marketing materials which will include, but not be limited to, its newsletters, website, mailings and general information brochures. We always do our best to share material involving our families with them prior to printing or sharing with potential donors.**

Child's name: _____

Parent/guardian Signature: _____ Date: _____

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Child's Information

Name: _____

Date of birth: _____

Medical Information

Child's diagnosis: _____

Date of diagnosis: _____/_____/_____

Physician Information

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Office phone: _____

Physician Signature

_____

Date: _____/_____/_____