Supporting families whose children suffer from life-threatening illnesses, diseases and disorders

FINANCIAL ASSISTANCE APPLICATION

Please include as much information as possible so that we can best determine your needs. All information provided is completely confidential. Also, **with your application, please submit copies of prior year tax returns for parents/guardians (first two pages)**. This information is required to process your application.

We will contact you as soon as possible upon receipt of your application, and advice with the status and next steps involved in processing your application.

Request for Assistance **Date:** ____________________

Contact Information: Parent/Guardian (Father) Information
Name: ____
D/O/B____
Day Phone:______________________________Evening:______________________________
Email:____
Address: ____
City: _________________________________State: ____________ Zip: _________________
Own or Rent :____

Parent Guardian (Mother) Information
Name:____
D/O/B____
Day Phone:______________________________Evening:______________________________
Email:____
Address:____
City: _________________________________State: ____________ Zip:_________________
Own or Rent: ____

Married_______ or Single_______ (check one)
How long have you lived at the above address?_____________________________________

Referral Information:
Name: ____
Address: ____
City: _________________________________State: ____________ Zip: _________________
Email: ____
Day Phone: _____________________________Evening: _____________________________
Relationship to Child: ____

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Child Patient Information

Child's Name: ____

Age: ____________D/O/B _____________Type of illness:____________________________

____

Prognosis: ____

Present Treatment____

____

Date Treatment Began: ____

Anticipated Completion of Treatment: ____

Hospital name: ____

Address where child is being treated: ____

Hospital telephone: ____

Doctors Name: ____

Doctors Phone: ____

Social Workers Name: ____

Social Workers Phone: ____

Do you give permission for social worker or case manager to release your information to Mitchell Thorp Foundation for review for assistance? ___ yes ____ no

Do you have any insurance? Yes______No______

If yes list name of company: ____

Secondary Insurance____

Childs Daily Regimen: ____

____

Childs Alternative Regimen: (i.e Hyperbaric therapy, vitamins, acupuncture, massage therapist etc.)______________________________ __________________________________

____

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FINANCIAL & EMPLOYMENT INFORMATION

Are you a US citizen? Yes_______ No_______

(If you are not but the child is please provide documentation or SS#___________________)

(Father/Guardian) Employment
Current Employer: ____
Position: ____
Address: ____
Phone: ____
Contact Person: ____
Salary: ____

(Mother/Guardian) Employment
Current Employer____
Position: ____
Address: ____
Phone: ____
Contact Person: ____
Salary: ____

Current Combined Family/Guardian Income
Applicant/Parent Salary____
Other Income: ____
Social Security Income____
IHSS____
Food Stamps____
Child Support____
Pension____
Unemployment____
Other____

Current Family Assets:
Checking Institution (Bank Name)____________________Balance______________________
Savings Institution (Bank Name)_____________________Balance______________________
Other Describe____
Stocks, Bonds, Annuities, Mutual Funds____
Balance____
Auto 1 (Year/Make)________________________________Value_______________________
Auto 2 (Year/Make)________________________________Value_______________________

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Expenses/Debts	Amount Owed	Mo Payment	Creditor
Mortgage/Rent	____________	___________	______________
Other Mortgage/Liens	____________	___________	______________
Auto Loan 1	____________	____________	______________
Auto Loan 2	____________	____________	______________
Credit Card	____________	____________	______________
Credit Card	____________	____________	______________
Medical Debts	____________	____________	______________
Health Insurance	____________	____________	______________
Car Insurance	____________	____________	______________
Child Support	____________	____________	______________
Childcare	____________	____________	______________
Other	____________	____________	______________

Estimated Expenses

Groceries: _____________________ Nearest Grocery Store: _________________________

Utilities: _______________________

Transportation Costs (Gas etc.)___________________Nearest Gas Station______________

Other Expenses: ____

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If you have received assistance from other organizations, please list them here:

1.____

2.____

3.____

What are your needs at this time for assistance?

____

____

____

How does the disability impact the primary care giver(s) ability to work?

____

____

____

Describe your support network: (family, friends, work, community, church, etc.)

____

____

Will your support network be willing to help out with fund raising efforts if needed?

____

____

How did you find out about our program?

____

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Application Agreement: I hereby apply for assistance to meet medical and/or non-medical expenses related to my child's medical care not covered by my private/public insurance or any other agency and that I cannot otherwise pay without undue hardship. The type and amount of assistance provided will be determined by Mitchell Thorp Foundation. I vouch for the truth and accuracy of all information given in this application. I authorize disclosure of information relevant to my child's medical condition to Mitchell Thorp Foundation. I also authorize disclosure to Mitchell Thorp Foundation of any information relevant to my application as well as any information from insurance or other pertinent agencies. I have been informed that any falsely submitted documentation or information will automatically disqualify this application and eligibility for any further assistance from this organization. I understand that Mitchell Thorp Foundation Board of Directors determines the amount they will assist for each family by a case-by-case basis.

Signed: Date________________Parent/Guardian _____________________________

Date________________Parent/Guardian______________________________

If filled out by social worker, please sign and date
Social Worker: ____Date:__________

OPTIONAL-I identify my ethnicity as:

- **African/American**
- **Asian/Pacific Islander**
- **Native American**
- **Mixed Descent**
- **White/Caucasian**
- **Hispanic/Latino**

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PUBLIC RELATIONS RELEASE

Upon receipt of parent approval, The Mitchell Thorp Foundation uses pictures of families and children we have helped in the past. This encourages our donors to keep contributing to our efforts in helping families whose children suffer from a life-threatening illness, disease, or disorders. Authorization for information release is voluntary and does not affect families' eligibility to receive financial assistance.

Parent/Guardian Authorization

I hereby give my consent to the Mitchell Thorp Foundation to use my child's story to be told. I release them from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed. (Please email some photos of child and family to beth@mitchellthorp.org)

Photographic and Video Release and Intellectual Property Rights.

I grant full permission and rights to use, without compensation, photographic images and videos of me and my children and quotations made by me and my children relating to our service in materials, advertisements, or other promotions for Mitchell Thorp Foundation. I understand that it is the policy of Mitchell Thorp Foundation to use only first-names, pseudonyms, or de-identified images, videos, or quotations in its materials to help protect my privacy and the privacy of my child(ren).

Parent/Guardian Print Name:____

Parent/Guardian Signature: ____

Date: ______________

Names and Ages of Minor Children:

Name: ____________________________________ Age: _____

Name: ____________________________________ Age: _____

Name: ____________________________________ Age: _____

Name: ____________________________________ Age: _____

Name: ____________________________________ Age: _____

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