Mitchell Thorp FOUNDATION

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 along with a few photos of child in treatment and one with the family)**. This information is required to process your application.

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

CONTACT INFORMATION

Date: _____

Parent/Guardian (Father) Information

Name: _____

D/O/B: _____

Cellphone number: _____

Email: _____

Address: _____

City: _____State: _____ Zip: _____

Parent/ Guardian (Mother) Information

Name:_____

D/O/B:_____

Cellphone number: _____

Email:_____

Address:_____

City: _____State: _____ Zip:_____

Parent's Marital Status: _____

Parent's Living Arrangement: _____

Child lives with (check all that apply):

_____ Mother _____ Father _____ Guardian

_____ Siblings

Name and DOB of Minor Siblings

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

I identify my ethnicity as:

- African/American
- Asian/Pacific Islander
- Native American
- Mixed Descent
- White/Caucasian
- Hispanic/Latino
- Other: _____

Child interest information: (For our Triumph Together Program)

Favorite Sport: _____

Favorite Athlete: _____

Favorite Team: _____

Favorite Hobby: _____

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CHILD/PATIENT INFORMATION

Child's Name: _____

Age: _____D/O/B: _____Type of illness: _____

_____

Relapse: _____ Yes _____ No

Prognosis: _____

Present Treatment: _____

_____

Date Treatment Began: _____

Anticipated Completion of Treatment: _____

Hospital name: _____

Address where child is being treated: _____

Hospital telephone: _____

Doctor's Name: _____

Doctor's Phone: _____

Social Worker's Name: _____

Social Worker's 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 etc._____

_____

_____

EMPLOYMENT & FINANCIAL INFORMATION

(Father/Guardian) Employment

Current Employer: _____

Position: _____

Address: _____

Phone: _____

Contact Person: _____

Income: _____

Primary Language: _____ English _____ Spanish _____ Other

Are you a US citizen? _____ Yes _____ No

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

(Mother/Guardian) Employment

Current Employer: _____

Position: _____

Address: _____

Phone: _____

Contact Person: _____

Income: _____

Primary Language: _____ English _____ Spanish _____ Other

Are you a US citizen? _____ Yes _____ No

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

Current Combined Family/Guardian Income

Total Household Income: _____

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: _____

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 Per Month

Groceries: _____ Nearest Grocery Store: _____

Utilities: _____

Transportation Costs (Gas etc.): _____Nearest Gas Station: _____

Other Expenses: _____

_____

Have you received assistance from other organizations, please list them here and $ amount.

1._____

2._____

3._____

What are your needs currently for assistance?

_____

_____

_____

How does 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 with fundraising 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 the 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:_____

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PUBLIC RELATIONS RELEASE

Please provide the foundation with a few photos of the child in treatment and with the family, along with the application. 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: _____

Referral Information

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Email: _____

Cellphone: _____

Relationship to Child: _____