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**. 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: _____

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 photograph and 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 below. (Please email some photos of child and family to beth@mitchellthorp.org)

Parent/Guardian Name:_____

Parent/Guardian Signature: _____

Date: _____

Names and Ages of Minor Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____Age: _____