



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 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: _____
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# _____)

Parent/ Guardian (Mother) Information

Name: _____
D/O/B: _____
Cellphone number: _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
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# _____)



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Parent's Marital Status: _____

Parent's Living Arrangement: _____

Child/Patient 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: _____



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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 therapist etc.) _____



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EMPLOYMENT & FINANCIAL INFORMATION

(Father/Guardian) Employment

Current Employer: _____
Position: _____
Address: _____
Phone: _____
Contact Person: _____
Income: _____

(Mother/Guardian) Employment

Current Employer: _____
Position: _____
Address: _____
Phone: _____
Contact Person: _____
Income: _____

Current Combined Family/Guardian Income

Total Household Income: _____
Other Income: _____
Social Security Income: _____
IHSS: _____
Food Stamps: _____
Child Support: _____
Pension: _____
Unemployment: _____
Other: _____



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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

	<u>Amount Owed</u>	<u>Mo Payment</u>	<u>Creditor</u>
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	_____	_____	_____



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

1. _____
2. _____
3. _____

What are your greatest 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 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 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

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: _____