13124 Six Forks Road, Raleigh, NC 27614
FightLikePAXTON@gmail.com
www.FightLikePAXTON.com

APPLICATION FOR ASSISTANCE

Guidelines for Financial Assistance

Financial assistance provided by Fight Like PAXTON (FLP) is made possible because of generous donors. These funds are made available for families with the greatest need. To apply for financial assistance please email or mail completed copy to address listed above. Any child diagnosed with cancer on or before his/her 18th birthday and treated before his/her 21st birthday is eligible for consideration. The family must be referred by their physician or assigned social worker. Any child diagnosed with cancer must come from a family currently experiencing financial stress.

- Child's cancer treatment prevents parent from working, resulting in financial distress
- Child must be 21 years and under
- Child/family must be referred by their physician or assigned social worker who will in turn provide them with a FLP Application for Assistance
- Child's caregiver must complete a financial assistance application with the hospital social worker
- Original application must be delivered to FLP
- Copies of outstanding bills should be provided to FLP via email, mail or hand delivered and these must represent basic human necessities

After FLP Directors review the submitted application for assistance, if child is approved, the FLP officers will contact the child's caregiver.

FLP financial assistance checks are made payable to vendors. Cash disbursements may be given if deemed necessary by the Board of Directors.

The FLP Directors reserve the right to waive any of the stated requirements as they deem appropriate.

PERSONAL INFORMATION

Patient's Name:_____ Male __ Female __ Birth Date: _____
Parent/Guardian's Name:_____
Street Address: _____
City:_____ State:_____ Zip:_____
Home Phone: (_____)_____ Work Phone: (_____)_____
Cell Phone: (_____)_____ E-Mail_____
Primary Language Spoken:_____
Annual Household Income:_____
Individuals in household: _____Adults _____Children
Siblings Names & Ages:_____
Patient's Interests & Hobbies: _____

MEDICAL INFORMATION (This section must be completed by medical personnel)

Diagnosed Illness:_____ Date Diagnosed: _____
Attending Physician:_____ Phone: (_____) _____
Treatment Facility:_____ Social Worker's Name:_____
Signature of Medical Personnel: _____ Date: _____

Please have your social worker submit a statement regarding your family's current financial situation.

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OTHER INFORMATION

How did you hear about Fight Like PAXTON?: _____

_____

Use the space below to describe medical and non-medical expenses that a grant of financial assistance could help alleviate (e.g., utility bills, transportation, etc.). Please list most urgent needs first and attach additional sheet if necessary.

_____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL RECORDS AND CONSENT

This Authorization for Release and Use of Medical Records ("Release") and Consent authorizes the release and use of Protected Health Information. The undersigned (the "Releasor") authorizes Fight Like PAXTON (FLP), a North Carolina Unincorporated Non-Profit Association to release and utilize the Releasor's medical information as it relates to FLP's activities, and permits authorized FLP personnel to speak directly with the child's medical providers and social workers. The Releasor further consents to the dissemination and use of the child's name, likeness, and recorded voice singularly or in conjunction with other photograph's and/or recording by the print, television, and radio media, for the purposes of pediatric cancer awareness and for raising funds to further the goals of FLP in providing financial assistance to families of children with cancer. The Releasor acknowledges that he/she has the right to revoke the authorization at any time and that once the information is released, it may no longer be protected under federal law. The Releasor understands that he/she may revoke this authorization in writing, signed by Releasor. The revocation will only be effective upon receipt by FLP.

The undersigned do hereby affirm as follows:

1. The undersigned are the parents or guardians of the child listed above.
2. The undersigned agree to return any unused funds immediately to FLP so that those funds can be utilized by FLP to benefit other families.
3. The undersigned acknowledges and agrees to maintain records that will be made available to FLP upon reasonable request, detailing the expenditures made from the funds provided by FLP. FLP will pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including any attached sheets, is true and correct to the best of my knowledge.

_____	_____	_____
Signature	Printed Name	Date