The Pamela Caglianone Foundation

Application for Assistance

Last Name_____ First Name_____

Date of Birth _____ Sex: M / F

Address_____ Permanent / Temporary

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Guardian Information (if under 18)

Mothers Name_____ Fathers Name_____

Address_____ Address_____

City, State, Zip_____ City, State, Zip_____

Home Phone_____ Home Phone_____

Cell Phone_____ Cell Phone_____

Work Phone_____ Work Phone_____

Employer_____ Employer_____

Health Insurance_____ Health Insurance_____

Medical Information

Medical Condition_____

Physician_____ Date Diagnosed_____

Address_____

Office Phone_____ Fax Number_____

Health Insurance_____ Policy Holder_____

Phone Number_____ Policy Number_____

Type of Assistance

Please describe the type of assistance that you are seeking. If you are seeking monetary assistance, you must fill out the Financial Information form.

_____

_____

_____

Financial Information

Household Income

Salaries	_____
Alimony	_____
Child Support	_____
Other Income	_____

Household Expenses

Mortgage	_____
Rent	_____
Utilities	_____
Groceries	_____

Auto Expenses _____

Health Insurance Expenses _____

Medical Treatment Expenses _____

Medication Expenses _____

Are you receiving other types of assistance? Yes / No

If Yes, Please explain_____

_____

You must include a test result, confirming a cancer diagnosis along with this application in order for your application to be considered for assistance by our board.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

The PCF may use, disclose or receive the following Protected Health Information: all medical records of the undersigned (the "Protected Health Information").

The Protected Health Information may be used, disclosed or received for the following purposes: To permit the PCF to evaluate the undersigned(s) request for financial or other assistance, including the undersigned(s) eligibility for assistance from The Pamela Caglianone Foundation, Inc.

This authorization shall remain in effect until the PCF completes its evaluation of the undersigned and for such longer period that the PCF believes such additional evaluation is necessary.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at the PCF. I understand that the revocation of this authorization is not effective to the extent that the PCF has relied upon it for the use or disclosure of the Protected Health Information prior to receiving my written revocation notice.

I understand that any Protected Health Information disclosed pursuant to this Authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I expressly acknowledge that the Covered Entity is not receiving remuneration, direct or indirect, for the use or disclosure of the protected health information.

Applicants Signature_____ Date_____

Applicants Social Security Number_____-_____-_____

Parent or Guardian Signature_____ Date_____

Parent or Guardian Social Security Number_____-_____-_____

Authorized Representative Signature_____ Date_____

Description of Personal Representative's Authority_____

For Foundation Use Only Date Received_____

Medical Verification_____ Insurance Verification_____ Financial Verification_____

Telephone Interview: Date_____ By Whom_____ With Who_____

Date Denied_____

Reason for Denial_____

Date Approved_____ Voted on by_____

Assistance Granted_____

The Pamela Caglianone Foundation

Publicity Authorization

Sometimes the PCF gets publicity about their events. In which case, recipient's names are sometimes mentioned. Recipient's names, photos and stories may also be included in our newsletter and website. Please choose if you agree to publicity or wish to remain anonymous.

☐ **PUBLICITY OK** Recipients authorize PCF to use their names, likenesses and other information about them and their families, including medical condition. This information may be in photographs, videotapes, recordings, internet or any other format for purposes of promotion, publication, advertising, or any other purpose whatsoever, now or at any time in the future. Recipients understand and agree that the PCF may use any such information in any manner and media whatsoever, whether now known or hereafter invented, including electronic and print media and the Internet. Recipients understand and agree that the PCF may use any such information with or without Recipients' names and without the payment of royalties or other compensation to anyone, and without the need to notify them or to seek further approval before doing so.

_____

DATE Signature of Recipient or Representative if **authorizing publicity:**

☐ **NO PUBLICITY** Recipients request that information about their involvement with the PCF not actively publicized by the PCF either in print news media, posted on the Internet, or used in newsletters and brochures. However, each Recipient understands and agrees that, in order to make a decision regarding assistance, information regarding the applicant will necessarily be discussed with and disclosed with the PCF. The Pamela Caglianone Foundation may publicly describe the general situation, without specifically identifying the Recipient and family, and that even if the PCF does not actively pursue publicity, the general public and media may obtain information concerning Recipients' involvement in the PCF from other sources.

_____

DATE Signature of Recipient or Representative if **NOT authorizing publicity:**

Recipients or their representatives acknowledge reading and understanding this Release and Authorization. For the minor Recipient, the signature of their parent or guardian is on behalf of the minor. Recipients agree that this Release and Authorization fully and accurately expresses their understanding and has not been modified orally or in writing.

_____ _____

Date Recipient (if not a minor)

_____ _____

Date Parent or Legal Guardian of minor Recipient Relationship

_____ _____

Date Authorized Representative of Recipient Description