Jen's Friends Application for Assistance

Jen's Friends Cancer Foundation is a 501(c)(3) non-profit organization,
which is dedicated to assisting residents of the Mount Washington Valley region
who are battling cancer, and who lack sufficient health insurance or financial resources.
We do not pay medical expenses or past debt of any kind.

Please send completed application to:

Jen's Friends Cancer Foundation
PO Box 1842
North Conway, NH 03860

If you have questions, contact us at
(603) 356-5083

IMPORTANT!

You must sign the releases on pages 4 & 5
<u>before</u> sending us this application.
Only completed applications will be considered.

All information is strictly confidential

Jen's Friends Application for Assistance

For Office Use Only
Date Rec'd:
File No.:

NOTE: All information will be kept strictly confidential.
Only completed applications will be considered.

Application Date:
Applicant's Name:
Age: Date of Birth: Male Female
Social Security Number:
Phone:_____
Mailing Address:
City: State: Zip:
Physical Address if different from mailing address:

City: State: Zip:
Employer Name:
Address:
City: State: Zip:
Spouse/SignificantOther:_____
Spouse/Significant Other Employer : _____
Address:
City: State: Zip:

ILLNESS:
Diagnosis:

Date Diagnosed: General Prognosis:
Current Treatment Plan:

MEDICAL CONTACTS:
The following information is necessary, so that we may verify your condition.

	Physician	**Social Worker**
Name:		
Address:		
Phone:		

If someone other than the applicant is submitting this application, please complete the following:

Name: Relationship:
Address:
City: State: Zip:
Phone:

REQUIRED: Name and contact information of person other than yourself that Jen's Friends can contact if we have questions concerning arrangements for distribution of funds:

Name: Relationship:

Address:

City: State: Zip:

Phone:

List current sources of income for yourself and for other members of your household:

	Applicant	**Spouse**	**Other Household Members**
Wages	$	$	$
Social Security	$	$	$
Disability Income	$	$	$
Other	$	$	$
Total Income per Year	$	$	$

RESIDENCE:

Do you or your family OWN_____ or RENT _____ the home in which you are living?

What is the current mortgage? $_____ What is your current rent?_____

Average monthly expenses for utilities? $_____

Type of heat: Avg. Cost: $

Electric provider: Avg. Cost: $

Phone carrier: Avg. Cost: $

Any other costs (i.e., water, home owners association fee, car payments):

OTHER ASSISTANCE FOR WHICH APPLICANT HAS APPLIED:

If applicable, describe the following assistance, for which you have applied:

Health Insurance (list insurer):

Medicare/Medicaid:

Fuel assistance, Social Security Disability, aid from the Town Welfare Office, food stamps, aid from the Veteran's Administration, etc.

Other:

Please mention any other facts you would like us to consider while discussing your request:

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ASSISTANCE OR RESOURCES REQUESTED:

List the types of financial assistance or resources you are applying for, how can we help you? (Note: We cannot pay for medical expenses, taxes or past due bills or debts):

Jen's Friends is a 100% volunteer organization. Once you have completed and returned this application a member of the disbursement committee will contact you for a brief review. You will then be assigned a contact person from the committee who will work with you to help address your requests. The committee meets once a month to review and disburse the funds available for that month.

General Release

I/We wish to participate in the benefits provided by Jen's Friends Cancer Foundation of New Hampshire.

I/We understand that our participation in such a program is wholly voluntary and that these benefits are provided by "Jen's Friends Cancer Foundation" in furtherance of its humanitarian endeavor to provide financial support to Mount Washington Valley area residents who are battling cancer without the assistance of health insurance and/or who are in financial difficulties.

I/We hereby assume all risks and responsibility for any damage or injury (including the aggravation of any existing illness or condition), which I, or my family, may sustain as a result of our participation in the benefits provided by "Jen's Friends Cancer Foundation," its officers, directors, agents, sponsors, medical advisors, volunteers, and employees.

I/We hereby release, discharge, indemnify and agree to hold harmless "Jen's Friends Cancer Foundation," its officers, directors, agents, sponsors, medical advisors, volunteers, and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by "Jen's Friends Cancer Foundation."

In Witness thereof this day of , (year)

Signed: **Date:**

Witness: **Date:**

Please remember that Jen's Friends funds are raised by your friends, neighbors, and community.
We are pleased to be able to provide support and assistance when applicable.
In return we ask that you be honest and respectful in your requests and remain good stewards of this community organization.
Thank you.

Authority to Release Hospital Records and/or Divulge Medical Information

1. **Primary Care Provider / Hospital :**
   Address:

   In regard to your patient named: Age:_ DOB:

   You are hereby authorized to furnish a release to *Jen's Friends Cancer Foundation** all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

   Signed: Date:
   (Patient or adult with authority to act for minor)

   Witness: Date:

2. **Oncologist / Hospital:**
   Address:

   In regard to your patient named: Age:_ DOB:

   You are hereby authorized to furnish a release to *Jen's Friends Cancer Foundation** all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

   Signed: Date:
   (Patient or adult with authority to act for minor)

   Witness: Date:

3. **Other / Hospital:**
   Address:

   In regard to your patient named: Age:_ DOB:

   You are hereby authorized to furnish a release to *Jen's Friends Cancer Foundation** all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

   Signed: Date:
   (Patient or adult with authority to act for minor)

   Witness: Date:

*Jen’s Friends Cancer Foundation is a non-profit organization, which provides non-medical supplemental financial assistance to cancer patients in the Mount Washington Valley region.