

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 Pamela Caglianone Foundation, herein known as 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