JOE CASSELLA FOUNDATION FINANCIAL ASSISTANCE APPLICATION

Please fill out this form with complete and accurate information and fax it to (571) 918-4566 or email it to vivi@joecassellafoundation.org.

Applicant's Name: _____ **Relationship to patient:** _____

Home Address: _____

Phone: _____ **Email:** _____

Patient's Name: _____ **Patient's DOB:** _____

Patient's Home Address: _____

Name(s) of medical facilities where patient is currently treated: _____

Name/contact information of case manager/social worker: _____

Health insurance provider (if applicable): _____

Please describe the medical emergency that is impacting the family:

Signature: _____ **Date:** _____

Please note that if you are selected as a qualified applicant, we may request a HIPPA authorization form to be completed to obtain your medical bills if needed or verify that your child is a patient receiving treatment.

1232 Barksdale Drive, NE
Leesburg, Virginia 20176
e info@joecassellafoundation.org
t 571.228.5150

JOECASSELLAFOUNDATION.ORG

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PUBLICITY

As the parent or guardian of the minor child identified below, I authorize the Joe Cassella Foundation to use or disclose protected limited health information for publicity, including but not limited to Websites, newspaper, magazine, radio, videotape, and other published material.

- This form does not authorize the disclosure of written or printed medical records.
- I can revoke this authorization by notifying the Joe Cassella Foundation by phone, in person or in writing.
- If I do revoke the authorization, it will not affect any actions that the Joe Cassella Foundation will or has already taken based on this form.
- I understand that I do not have to sign this form for my child to get financial assistance from the Joe Cassella Foundation. By signing this form, I acknowledge that I have read and agreed to its terms.

Information to be used or disclosed:

I authorize the use of my child's name, age, sex, city of residence, general nature of condition, treatment, and prognosis. If applicable, and provided to us, an image in photograph, video, or audio recording may be used for publicity purposes:

Signature of Parent/Guardian: _____ **Date:** _____

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