Application for Family Assistance

Application Guidelines

- Anyone age 18 or younger who is currently receiving treatment for a brain tumor is eligible to apply for the Christopher Brandle Joy of Life Foundation Family Assistance Program.

- In order to be considered, applications must be completed in full and submitted by a hospital social worker.

- Payment will only be made to third parties.

- Copies of all third party invoices must be submitted with this application.

- The Foundation will determine amount of financial assistance based on information provided.

- Examples of covered expenses include (but not limited to):
  - Rent or mortgage payments
  - Travel and lodging expenses incurred during treatment
  - Car payments
  - Expenses incurred during treatment, not covered by medical insurance

All information is confidential and solely for the use of the Christopher Brandle Joy of Life Foundation Family Assistance Program.

Any questions should be directed to the Christopher Brandle Joy of Life Foundation at **cbjoyoflife@optonline.net**.

Please mail completed application to:

The Christopher Brandle Joy of Life Foundation
PO Box 354
Oakland, NJ 07436

Completed applications can also be emailed to: **cbjoyoflife@optonline.net**

Christopher Brandle Joy of Life Foundation

Application for Family Assistance

Patient's Last Name: _____ Patient's First Name: _____

Age: _____ Date of Birth: _____

Parent(s)/ Guardian / Caregiver First and Last Name(s): _____

Phone Number: _____ _____
Home Cell

Address: _____

City, State Zip _____

Patient Diagnosis: _____
(Please include Date of Diagnosis)

Siblings: _____
(Please provide Name(s) and Age(s))

_____

Adults Living in Household and place of Employment: _____

_____

Is patient covered by medical insurance?: _____ Yes _____ No

Name of Provider: _____

Approximate Annual Household Income (please circle):
Under $25,000 $25,000 - $75,000 $75,0000 - $150,0000 Over $150,000

How did patient's family hear about the Christopher Brandle Joy of Life Foundation Family Assistance Program?

_____

Has the family applied for any other Family Assistance Programs (please list): _____

_____

Hospital and Social Worker Information

Name of Hospital and Location: _____

Name of Oncologist: _____ Phone: _____

Name of Social Worker: _____

Social Worker Phone: _____ Email Address: _____

Christopher Brandle Joy of Life Foundation

Request Information

Amount Requested: _____

Reason for Request: _____

_____

_____

Payee Information - Payment to Third Party (attached additional sheets if necessary and copies of all invoices)

Name of Payee: _____

Invoice or Account #: _____

Address, City, State Zip: _____

Additional Information: Please provide the Christopher Brandle Joy of Life Foundation with any additional information that might help us in determining family's need for assistance.

_____

_____

_____

Signatures

By signing below, I acknowledge the following:

- I am an authorized representative of the referenced hospital.
- I am authorized to submit this application on behalf of the patient and their family.
- A parent or guardian of the patient has given their consent to provide truthful information in this application.

Social Worker Signature: _____

Social Worker Name: (Please print) _____

Parent / Guardian Signature: _____

Parent / Guardian Name: (Please print) _____

Date: _____