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

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?
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Has the family applied for any other Family Assistance Programs (please list): ____________________
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Hospital and Social Worker Information

Name of Hospital and Location: ____________________

Name of Oncologist: ____________________ Phone: ____________________

Name of Social Worker: ____________________

Social Worker Phone: ____________________ Email Address: ____________________

Request Information

Amount Requested: ____________________

Reason for Request: ____________________

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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.

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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: ____________________