



Supporting families whose children suffer from life-threatening illnesses, diseases, and disorders

FINANCIAL ASSISTANCE APPLICATION

Please include as much information as possible so that we can best determine your needs. All information provided is completely confidential. Also, **with your application, please submit copies of prior year tax returns for parents/guardians (first two pages)**. Please provide the foundation with a few photos of the child in treatment and with the family, along with the application. This information is required to process your application.

We will contact you as soon as possible upon receipt of your application and get back with the status and next steps involved in processing your application.

Parent/Guardian Information

Date: _____

Name: _____

D.O.B: _____ Relation to Child: _____

Cellphone number: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Current Employer: _____

Position: _____

Address: _____

Phone: _____ Income: _____

Parent/Guardian Information _____ Date: _____

Name: _____

D.O.B: _____ Relation to Child: _____

Cellphone number: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Current Employer: _____

Position: _____

Address: _____

Phone: _____ Income: _____

Parent/Guardian Marital Status: _____



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Parent/Guardian Living Arrangement: _____

Child lives with (check all that apply):

☐ Mother ☐ Father ☐ Guardian ☐ Siblings

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Are you a US citizen? ☐ Yes ☐ No

(If you are not but the child is, please provide child's documentation or SS# _____)

Name and DOB of Minor Siblings

Name: _____ D.O.B: _____ Age: _____

Name: _____ D.O.B: _____ Age: _____

Name: _____ D.O.B: _____ Age: _____

Name: _____ D.O.B: _____ Age: _____

I identify my ethnicity as:

☐ African American

☐ Asian/Pacific Islander

☐ Native American

☐ Mixed Descent

☐ White/Caucasian

☐ Hispanic/Latino

☐ Other: _____

Child Interest information: (For our Champion Day Program)

Favorite Sport: _____

Favorite Athlete: _____

Favorite Team: _____

Favorite Hobby: _____



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Child/Patient Information

Child's Name: _____ Age: _____ D.O.B: _____ Gender: _____

Type of Illness: _____

Relapse: ☐ Yes ☐ No Prognosis: _____

Present Treatment: _____

Date Treatment Began: _____ Anticipated Completion of Treatment: _____

Hospital Name: _____

Treatment Facility Address: _____

Hospital Telephone: _____

Doctor's Name: _____

Doctor's Phone: _____

Social Worker's Name: _____

Social Worker's Phone: _____

Do you give permission for social worker or case manager to release your information to Mitchell

Thorp Foundation for review for assistance? ☐ Yes ☐ No

Do you have any insurance? ☐ Yes ☐ No

If yes, list name of company: _____

Secondary Insurance: _____

Does your household receive federal health insurance assistance? ☐ Yes ☐ No

Childs Daily Regimen: _____

Childs Alternative Regimen: (i.e Hyperbaric therapy, vitamins, acupuncture, massage therapist etc.)



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Current Combined Family/Guardian Income

Total Household Income: _____

Other Income: _____

Social Security Income: _____

IHSS: _____

Food Stamps: _____

Child Support: _____

Unemployment: _____

Other: _____

Current Family Assets

Checking Institution (Bank Name): _____ Balance: _____

Savings Institution (Bank Name): _____ Balance: _____

Other- Describe: _____

Auto 1 (Year/Make): _____ Value: _____

Auto 2 (Year/Make): _____ Value: _____

	<u>Amount Owed</u>	<u>Mo. Payment</u>	<u>Creditor</u>
Mortgage/Rent	_____	_____	_____
Other Mortgage/Liens	_____	_____	_____
Auto Loan 1	_____	_____	_____
Auto Loan 2	_____	_____	_____
Credit Card	_____	_____	_____
Medical Debts	_____	_____	_____
Health Insurance	_____	_____	_____
Car Insurance	_____	_____	_____
Child Support	_____	_____	_____



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If you have received assistance from other organizations, please list them here with dollar amount:

1. _____
2. _____
3. _____

What are your needs at this time for assistance?

Describe your support network: (family, friends, work, community, church, etc.)

Will your support network be willing to help with fundraising efforts if needed? ☐ Yes ☐ No

Sometimes families choose to have a fundraising page where friends, family, and community members can contribute. Would you like us to provide you with more information about this option?

☐ Yes ☐ No

How did you find out about our program? _____

We occasionally highlight family stories (always with permission) to help raise awareness and offer hope to others. If your family or child has a public social media presence and you'd be open to us viewing it or potentially connecting in the future for awareness opportunities, feel free to share below.

Would you like to share a social media page with us?

☐ Yes ☐ No

If yes, please list handle(s) or link(s):

Instagram: _____

TikTok: _____

Facebook: _____



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Application Agreement: I hereby apply for assistance to meet medical and/or non-medical expenses related to my child's medical care not covered by my private/public insurance or any other agency and that I cannot otherwise pay without undue hardship. The type and amount of assistance provided will be determined by Mitchell Thorp Foundation. I vouch for the truth and accuracy of all information given in this application. I authorize disclosure of information relevant to my child's medical condition to Mitchell Thorp Foundation. I also authorize disclosure to Mitchell Thorp Foundation of any information relevant to my application as well as any information from insurance or other pertinent agencies. I have been informed that any falsely submitted documentation or information will automatically disqualify this application and eligibility for any further assistance from this organization. I understand that Mitchell Thorp Foundation Board of Directors determines the amount they will assist for each family by a case-by-case basis.

Signed: Date: _____ Parent/Guardian: _____

Date: _____ Parent/Guardian: _____

If filled out by social worker, please sign and date

Social Worker: _____ Date: _____



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PUBLIC RELATIONS RELEASE

Please provide the foundation with a few photos of the child in treatment and with the family, along with the application. Upon receipt of parent approval, The Mitchell Thorp Foundation uses pictures of families and children we have helped in the past. This encourages our donors to keep contributing to our efforts in helping families whose children suffer from a life-threatening illness, disease, or disorders. Authorization for information release is voluntary and does not affect families' eligibility to receive financial assistance.

Parent/Guardian Authorization

I hereby give my consent to the Mitchell Thorp Foundation to use my child's story to be told. I release them from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed. (Please email some photos of child and family to beth@mitchellthorp.org)

Photographic and Video Release and Intellectual Property Rights.

I grant full permission and rights to use, without compensation, photographic images and videos of me and my children and quotations made by me and my children relating to our service in materials, advertisements, or other promotions for Mitchell Thorp Foundation. I understand that it is the policy of Mitchell Thorp Foundation to use only first-names, pseudonyms, or de-identified images, videos, or quotations in its materials to help protect my privacy and the privacy of my child(ren).

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____

Date: _____

Referral Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cellphone: _____ Relationship to Child: _____