Application for Assistance

Please print when filling out application in blue/black ink.

Patient Last Name: ____

Patient First Name: ____

Patient Middle Name/Initial: ____

Patient SSN: ____

Patient Date of Birth: ____

Present Physical Address: ____

County: ____

Present Mailing Address: ____

Home Phone: ____

Cell Phone: ____

Message Phone: ____

Email: ____

Full Name of Applicant/Caregiver (If Different than Patient): ____

Applicant Relationship to Patient: ____

Employer (Of caregiver/guardian if patient is a minor):____

Diagnosis: ____

Diagnosis Date: ____

Treatment Protocol (Chemo, Radiation, Transplant, etc.): ____

____

Treatment Location (Name, Address, Phone Number): ____

____

____

How Many Times a Month is Treatment Received?:____

Current Treatment Status (Newly diagnosed, Treatment in progress, Remission, Etc.): _______________________

____

Physician Information (Name, Address, Phone): ____

____

____

Government Assistance Received as Patient/on Behalf of Patient (Social Security, Food Stamps, Government Cash Aid, etc,): ____

____

Total Monthly Government Assistance Amount Received: ____

Do you have a GoFund me account, or other similar fundraising account for you/patient?: ___________________

If so, how much?: ____

Please list all family members responsible for patient care:

1. **Name, Relationship to Patient, Age:**

   ____

2. **Name, Relationship to Patient, Age:**

   ____

3. **Name, Relationship to Patient, Age:**

   ____

4. **Name, Relationship to Patient, Age:**

   ____

North Valley Sparrow Foundation provides families we serve in Northern California rural communities with pre-paid gas cards, pre-paid grocery/restaurant cards, help with payments for utilities, rent/mortgage, car repairs/tires, traveling, & lodging, medical treatments/supplies and alternative treatments not covered by insurance, and emotional support services for patients and caregivers. No cash payments will be distributed directly to recipient. All monetary funds will be paid directly to third party vendors on behalf of patients and their caregivers.

FINANCIAL ASSISTANCE WILL NOT BE DISTRIBUTED IN BULK MONETARY AMOUNTS UNLESS BY SPECIAL BOARD APPROVAL. ALL FINANCIAL ASSISTANCE WILL BE DISTRIBUTED ON A CASE BY CASE BASIS, BASED ON URGENCY, CONSIDERED IN THE ORDER IN WHICH REQUESTS ARE RECEIVED. PLEASE NOTE, A REQUEST FOR FUNDS IS IN NO WAY INDICATIVE OF GUARANTEED RECEIPT OF FUNDS. North Valley Sparrow Foundation strives to serve as many families as possible, noting that fund availability fluctuates throughout the year.

THE FOLLOWING SECTION MUST BE COMPLETED TO BE CONSIDERED FOR A DONATION.

Requested Monetary Amount:____

Contact Information for Bills to be Paid (Ex: Landlord, Utility Company, Physician, etc.): ____________________

____

____

Account # for Vendor(s) if Applicable: ____

Photo copy of statement/bill to be paid (Circle if applicable): <u>SEE ATTACHED Statement/BILL</u>

Date of Request: ____

Questions? Contact: **Kathryn Sheppard**
530.693.1520
nvsparrowfoundation@gmail.com

Provide a brief description of need. (300 words or less)

Other pertinent information you would like to share. (300 words or less)

Please return application, including HIPPA release form, to:
North Valley Sparrow Foundation
Attn: Request for Funds
P.O. Box 1283 Biggs, CA 95917
nvsparrowfoundation@gmail.com

North Valley Sparrow Foundation is a 501(c)(3) nonprofit. FEIN#82-1624777.

HIPPA RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability & Accountability Act, 45 C.F.R., Parts 160 & 164)

Privacy regulations require the North Valley Sparrow Foundation to obtain a release signed by patients (or their representative) so we may speak with family members, friends and other third parties regarding patient medical treatment and financial information.
Each person you wish to be considered a contact must be listed individually by name (including a spouse, child, parent or significant other).
Please print name, relationship to patient, and telephone number for each person to whom you are authorizing release of your private healthcare information and financial balances.
Please photocopy should you require more space.

Name____ **Relationship**___________________ **Phone**_________________

Name____ **Relationship**___________________ **Phone**_________________

Name____ **Relationship**___________________ **Phone**_________________

Name____ **Relationship**___________________ **Phone**_________________

Name____ **Relationship**___________________ **Phone**_________________

This authorization covers the period from ________ to _______ **OR** all past, present & future periods ☐(check box).

This medical/financial information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that receipt of benefits from the North Valley Sparrow Foundation is not conditional upon whether I sign this release.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient, through no fault of the North Valley Sparrow Foundation, and may no longer be protected by Federal or State law.

____

Patient/Representative Signature | Printed Name | Date

____

Witness Signature | Printed Name | Date