

## PO BOX # 7584 CUMBERLAND, RI, 02864 WWW.NATHANSANGELS.COM

## FINANCIAL APPLICATION

PATIENT INFORMATION:
DATE OF APPLICATION:
NAME:
ADDRESS:
DATE OF BIRTH:
AGE:
SEX: FEMALE MALE
PARENT INFORMATION:
NAME:
ADDRESS:
CITY/STATE/ZIPCODE:
HOME PHONE:
CELL PHONE:
EMAIL:

MEDICAL INFORMATION:

DIAGNOSIS:
DATE OF DIAGNOSIS:
IS YOUR CHILD IN ACTIVE TREATMENT:
WHAT TYPE OF TREATMENT:
CHEMOTHERAPY SURGERY STEM CELL TRANSPLANT
BONE MARROW TRANSPLANT RADIATION OTHER:
WHAT IS THE ANTICIPATED LENGTH OF TREATMENT:
WHERE IS THE PATIENT BEING TREATED:
ONCOLOGIST/SOCIAL WORKER  NAME:  EMAIL:  PHONE NUMBER:
SIGNATURE OF HEALTHCARE PROVIDER DATE
WHO LIVES IN THE HOME? NAMES AND AGES (SIBINGS PARENTS GRANDPARENTS)

TELL US ABOUT YOUR HERO AND DESCRIBE FINANCIAL NEED:
Have you received any financial support from other organizations or have been recipient of a fundraiser ( )Yes ( ) NO If yes, please lists name and amounts received:
We at Nathan's Angels Memorial Foundation respect your privacy. All information on this form is for
the purpose to assess and grant you financial assistance. Our foundation uses photos of "OUR HEROES" on our website and Facebook page with a brief synopsis of your child's diagnosis and curren

We at Nathan's Angels Memorial Foundation respect your privacy. All information on this form is for the purpose to assess and grant you financial assistance. Our foundation uses photos of "OUR HEROES" on our website and Facebook page with a brief synopsis of your child's diagnosis and current condition. While we hope that you are willing to allow your child to be part of "OUR HEROES" and/or a photo to be used of your child for advertising and event purposes, we understand and respect your privacy and this will not determine your qualifying for assistance. Please see the attached Photo and Information Release Form.

child by email to utilize on day of event and on our Facebook page ***		
***If selected as a recipient please submit a photo and 3-4 sentences about your		
web content.		
including but not limited to: publicity, copyright purposes, illustration, advertising, and		
Foundation my permission to use the photographs and story enclosed for any legal use		
[Child] grant Nathan's Angels Memorial		
I,, the parent or legal guardian of		
I grant to Nathan's Angels Memorial Foundation, its representatives the right to use photographs of my child in connection with the above-identified subject.		
PHOTO AND INFORMATION RELEASE FORM		
Do you authorize NATHAN'S ANGELS MEMORIAL FOUNDATION to use your child's story?  ( ) Yes ( ) No		
Do you authorize NATHAN'S ANGELS MEMORIAL FOUNDATION to use your child's photo?  ( ) Yes ( ) No		

## **IMPORTANT INFORMATION**

- All applications must be complete to be reviewed.
- Child must live in and/or surrounding communities of Rhode Island.
- Child must be under the age of 18.
- Child must be diagnosed with a critical cancer diagnosis and in active treatment.
- Applications are open yearly from April 15 through June 30. Once open please complete the application and mail or e-mail by June 30. New recipients will be chosen early July for the current year.
- The foundation hopes to assist as many families as possible but realizes the needs are great and not every request can be funded.
- All donations are based on financial need and availability of funds.

Please submit completed application by:	
Email:	Mail:
lucille@nathansangels.com	Nathan's Angels
	P.O. Box 7584
	Cumberland, RI 02864
I have read and understand the above:	
Parent/Guardian's Signature:	Date
Parent/Guardian's Name:	
Child's Name:	