CRISTIAN RIVERA FOUNDATION
"FULL STEAM AHEAD"

Mailing Address: P.O. Box 656, Edgewater, NJ 07020
551-313-0163 (Office) ◆ cristianriverafoundation.org

APPLICATION FOR FAMILY ASSISTANCE

ELIGIBILITY:	**CRF provides support for individuals who are going through active Diffuse Intrinsic Pontine Glioma (D.I.P.G.) treatment who are experiencing financial hardship as a direct result of their treatment.** Active treatment means you have an upcoming surgery, chemotherapy, or radiation to treat D.I.P.G.

DIRECTIONS:

- ☐ Fill out pages 1-4 of this application. Fax or mail those pages to CRF.
- ☐ Fill out page 5, and the top of page 6. Give BOTH pages to your doctor.
- ☐ After your doctor completes page 6, ask him/her to fax or mail **page 5, page 6 and your pathology report** to CRF.
- ☐ We will contact you once we have received your completed application (including the report from your doctor). **Your application will not be processed until we have all 6 pages.**
- ☐ Every page of the application must be completed.

Date of Application _____ **How did you hear about CRF?**_____

CONTACT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____

street address city state zip code

Home phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell phone: _____

Did someone help you with this application? ☐ No ☐ Yes Name: _____

Relationship: _____ Phone: _____

What medical insurance do you have?_____

Ethnicity (optional): _____ Preferred Language: _____

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HOUSEHOLD INCOME – *Full disclosure is required*	**Monthly Amount Before Diagnosis**	**Monthly Amount - Current**
1. Your wages/salary *if you are currently working* (after taxes)	1.	1.
2. Spouse/partner's wages/salary (after taxes)	2.	2.
3. Income from other contributing household member(s)	3.	3.
4. Roommate/Boarder	4.	4.
5. Disability (please circle) Accepted Pending Denied Date of application:	5.	5.
6. SSI/SSD (please circle) Accepted Pending Denied Date of application:	6.	6.
7. Social Security (please circle) Accepted Pending Denied Date of application:	7.	7.
8. Food Stamps (please circle) Accepted Pending Denied Date of application:	8.	8.
9. General Relief/Welfare (please circle) Accepted Pending Denied Date of application:	9.	9.
10. Unemployment Insurance (please circle) Accepted Pending Denied Date of application:	10.	10.
11. Child support/alimony	11.	11.
12. Other*	12.	12.
13. Other*	13.	13.
TOTAL OF ALL MONTHLY INCOME (Add lines 1 through 13):	**$**	**$**

*Examples: Non-profit assistance agencies, Veterans benefits, pension/retirement, rental property income, worker's compensation, interest/dividends, foster child support income, in-home care/in-home supportive services benefits, school grants/loans, or Financial assistance from other agencies **does not disqualify you** from receiving support from CRF.

MONTHLY EXPENSES – *Full disclosure is required*	**Monthly Amount Before Diagnosis**	**Monthly Amount - Current**
1. ☐ Mortgage or ☐ Rent	1.	1.
2. Gas _____ Electricity _____ Water _____ Trash _____ Cable _____	2. (total amount)	2. (total amount)
3. Telephone (land line) _____ Cellular phone _____	3. (total amount)	3. (total amount)
4. Food and household items (e.g., cleaning supplies, sundries)	4.	4.
5. Auto Loan _____ Auto Insurance _____ Gasoline _____	5. (total amount)	5. (total amount)
6. Medications (related to breast cancer treatment only)	6.	6.
7. Medical co-payments and/or share of cost of breast cancer treatment	7.	7.
8. Health insurance premiums	8.	8.
9. Other:	9.	9.
TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 9):	**$**	**$**

Why have your income and/or expenses changed during treatment?_____
If applicable, how much do you have in savings?____

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PHYSICIAN'S REPORT

The individual listed below has requested assistance from Cristian Rivera Foundation (CRF). **This form and a copy of the pathology report are required for this patient's application to be considered complete.** A signed release for the requested information is attached.

Attn: Cristian Rivera Foundation
P.O. Box 656
Edgewater, NJ 07020

Phone: 551-313-0163

SECTION I – TO BE COMPLETED BY APPLICANT	
Patient Name:	
Patient Date of Birth:	
Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:

SECTION II – TO BE COMPLETED BY PHYSICIAN – PLEASE <u>PRINT</u> CLEARLY			
Diagnosis:			
Date of diagnosis:		Date of last appointment:	
Planned Treatments			
Surgery (specify type)		Date of procedure	Expected recovery time
Chemotherapy (specify medications)		Start date	Expected end date
Radiation		Start date	Expected end date

Client's prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Other:

Specific physical limitations:

What level of employment activity is suitable for patient? ☐ Part-time ____ hours per week ☐ Full-time

Projected date patient can return to work at pre-treatment level:

Other prescribed medications:

Comments:

☐ **Copy of patient's pathology report is attached to this report**	
Physician's signature:	Date: