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

APPLICATION FOR MEDICAL 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 1-3 of this application. Fax or mail those pages to CRF.
- ☐ 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.

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 PRINT 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:	