ETHAN JOSTAD FOUNDATION
for childhood cancer

APPLICATION FOR FINANCIAL ASSISTANCE

This application is a request for financial assistance from the Ethan Jostad Foundation for Childhood Cancer. Our objective is to help offset the financial burden for families coping with childhood cancer. Please understand that our assistance is based on financial need, the current availability of funds, and provided to families that reside within the state of Oregon.

APPLICATION GUIDELINES AND INSTRUCTIONS

1. The patient must be under the age of 18 years old and in active treatment for a form of cancer.
2. This application must be completed by the child's parent/legal guardian only.
3. All sections of the application must be completed truthfully. Any false, incomplete, or misleading information will result in application denial and disqualify the applicant from all future assistance.
4. Section 2 of the application **must** be completed by a hospital social worker, Oncology RN, or MD.
5. Send completed applications to:

   Ethan Jostad Foundation for Childhood Cancer
   P.O. Box 1070
   Eagle Point, OR 97524

   You may also email the signed application to info@ethanjostadfoundation.org, or send it to us vial fax to (866) 879-9320.

SECTION 1: PATIENT & FAMILY INFORMATION

(Please Print)

_____ _____ _____ _____
Diagnosed Child's Name | Age | Date of Birth | Gender

_____
Parent or Legal Guardian Name (s)

_____ _____ _____ _____
Address | City | State | Zip Code

_____ _____ _____
Home Phone | Cell Phone | Email Address

By signing this application, I attest that all information provided is truthful and accurate. I also hereby grant the Ethan Jostad Foundation for Childhood Cancer permission to confirm/discuss my child's medical information with the social worker, Oncology RN, or MD, to share information about my child, and grant permission for publication of my child's name and condition (no financial need will ever be disclosed) for any material use by the foundation.

_____ _____
Parent/Legal Guardian Signature | Date

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SECTION 2: MEDICAL INFORMATION

(MUST BE COMPLETED BY A SOCIAL WORKER, ONCOLOGY RN, OR MD)

_____ _____
Type of Childhood Cancer Diagnosis Date of Diagnosis

_____ _____
Medical Facility or Hospital Currently Treating the Child Name of Child's Physician (Oncologist)

_____ _____ _____ _____
Physician's Address City State Zip Code

_____
Physician's Phone

Please describe the child's current medical condition and circumstances requiring the need for financial assistance.

By signing this application, I attest that all information provided is truthful and accurate.

_____ _____ _____
Name and Title of Medical Representative (print please) Phone Email Address

_____ _____
Medical Representative Signature Date