Application for Financial Assistance

In spirit of Jack's legacy and the gracious donations received from others, we are dedicated to offering financial assistance to those families that qualify. Please understand that our assistance program is based on financial need; although we would love to approve every application, we are limited due to donations received.

What Is Needed To Apply

1. Our program is for children under the age of 18 and must be in active treatment for cancer.
2. We must receive all pages to the application to be considered for the assistance program.
3. You are welcome to mail or email the signed package to : JackStrongFoundation@gmail.com
   The Jack Strong Foundation
   P.O. Box 395
   Bridgeport, WV 26330
4. The application must be completed by the parent or legal guardian.

Patient Information

Child's Name ______________ Age ______ Birth Date ______________

Parent or Guardian Name ______________

Mailing Address ______________ City/State ______________ Zip Code ______________

Telephone Number/Cell Number ______________

By signing below, I confirm that this information is in no way falsified or misrepresented. I agree to the terms and conditions of the application for Financial Assistance from The Jack Strong Foundation. I understand that not every application is considered approved. I grant permission for The Jack Strong Foundation to discuss my child's medical information with the Social Worker, Oncologist, Registered Nurse, and the person completing this application if other than a parent. I understand that The Jack Strong Foundation may use my information on their website, or Facebook Page. (None of my financial information will be shared)

Parent/Legal Guardian Signature ______________ Date ______ Email Address ______________

This portion of the application is to be completed by: Social Worker and/or Medical Doctor
Listed below is the medical information needed to help The Jack Strong Foundation understand the need for assistance.

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Name of Hospital/Treatment Facility

____________________________________ _______ ________________
Street Address State Zip Code

____________________________________ _______________________________
Oncologist Name Oncologist Telephone Number

____________________________________ ______________________________
Type of Cancer Diagnosis Diagnosis Date

Give a summary of current medical condition and plan of treatment that caused the need for financial aid:

Information above is accurate to the best of my knowledge.

____________________________________ _______________________________
Social Worker Signature Doctor Signature

____________________________________ _______________________________
Printed Name / Date Printed Name/Date

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Social Worker Email Address