# Application

**CHILD INFORMATION**

Child's Full Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____Age: _____ Date of Diagnosis: _____

Type of Cancer/Diagnosis: _____

**HOME ADDRESS:**

Street: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

**PARENT / LEGAL GUARDIAN INFORMATION**

**Parent/Legal Guardian Name #1**: _____

Relationship to Child: _____

Phone Number: _____ Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email

**Parent/Legal Guardian Name #2 (if applicable):** _____

Relationship to Child: _____

Phone Number: _____ Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email

**MEDICAL INFORMATION**

Hospital/Medical Facility Where Treatment Is Being Provided: _____

Treating Physician (Optional): _____

Social Worker / Child Life Specialist Name: _____

Phone Number: _____ Email Address: _____

**PATIENT'S INTERESTS & FAVORITES** (Check all that apply)

☐ Sports ☐ Electronics ☐ Art ☐ Fashion ☐ Music ☐ Shopping ☐ Outdoors ☐ Other _____

**STORES/FOOD** (Check all that apply)

☐ Amazon ☐ Walmart ☐ Target ☐ Roblox ☐ Nintendo eShop ☐ Pizza ☐ Fast Food ☐ Other _____

**TYPE OF ASSISTANCE REQUESTED** (Check all that apply)

☐ Gas/Travel ☐ Food/Groceries ☐ Utility Bills ☐ Lodging ☐ Medical Expenses ☐ Rent/Mortgage ☐ Other

Please briefly explain how these funds would help your family at this time:

_____

_____

_____

**MARSHALL KIDS CANCER FOUNDATION**
**RELEASE OF INFORMATION FORM**

I understand that submission of this application does not guarantee financial assistance, as funding is based on availability and eligibility criteria. Additional documentation may be requested to verify eligibility.

**Please Note**:
To qualify, the child must:

- Be between 0-18 years of age, and
- Have received a cancer diagnosis within the past 12 months, and
- Reside within Bond, Madison, Fayette, Clinton, or Montgomery County, Illinois.

**Authorization to Release Health Information**
I, the undersigned parent or legal guardian of the above-named minor child, hereby authorize hospitals, physicians, social workers, child life specialists, medical providers, and treatment facilities involved in my child's care to disclose protected health information to Marshall Kids Cancer Foundation, including its board members, employees, agents, and authorized representatives. This authorization permits the release of information necessary to verify eligibility for assistance and to coordinate support services. Such information may include confirmation of cancer diagnosis, date of diagnosis, general description of the medical condition, verification of treatment status, name of treatment facility, and general updates regarding the child's medical condition and well-being. This authorization also permits communication between Marshall Kids Cancer Foundation and the child's medical providers for the purpose of verifying information provided in applications for assistance and receiving periodic updates regarding the child's general condition as it relates to support services.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting a written request to Marshall Kids Cancer Foundation, except to the extent that action has already been taken in reliance upon it. I further understand that information disclosed pursuant to this authorization may no longer be protected by federal HIPAA privacy regulations once released to the Foundation.

**Media, Publicity, and Marketing Release**
I further grant Marshall Kids Cancer Foundation a perpetual, royalty-free, non-revocable license to use the child's and/or family's name, likeness, image, voice, photographs, video recordings, audio recordings, and written or spoken statements obtained during participation with the Foundation. I understand that these materials may be used for marketing, fundraising, promotional, educational, public awareness, donor communications, grant applications, social media, website content, printed materials, news releases, and event promotions. I acknowledge that no compensation will be provided for the use of such materials and that materials may be edited for clarity or length but will not be used in a misleading or defamatory manner.

**Please check one:**
☐ I give permission for photos/media use
☐ I prefer my child/family not be featured publicly

**Acknowledgment and Signature**
By signing below, I certify that I am the parent or legal guardian of the minor child listed above and that I have the legal authority to execute this Authorization and Release of Information on behalf of the child. I acknowledge that I have read and understand this document in its entirety and voluntarily agree to its terms.

**Parent/Legal Guardian Printed Name:** _____

**Signature:** _____ **Date:** _____

Please return this form by mail or email to:
Marshall Kids Cancer Foundation, 1127 IL Rt 127, Greenville, IL 62246, or: info@marshallkids.com.
Questions? (618) 367-0265