NewDay Foundation of La Porte Inc.
Application for Assistance

The NewDay Foundation of La Porte Inc. is a 501 (c) (3) nonprofit organization dedicated to assisting families of the La Porte County area who are battling cancer, and are in need of financial help for medical, health insurance, financial resources, and other assistance.

Send completed application to:

NewDay Foundation of La Porte Inc.
P.O. Box 13
La Porte, IN 46352

If you have questions, contact us at
(219) 851-2375

IMPORTANT!
You must sign the releases on page 4 before sending us this application.

All information is strictly confidential.

For Office use only
Date Rec'd_____
File No:_____

NewDay Foundation of La Porte Inc Application for Assistance

NOTE: ***All information will be kept strictly confidential except as necessary to confirm information as set out herein. Submission of application does not assure applicant will be granted assistance requested.***

Application Date: _____

Applicant's Name: _____
Age: _____ Date of Birth: _____ Male _____ Female _____
Social Security Number: _____

Mailing Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: _____
Physical Address if different from mailing address

ILLNESS
Diagnosis: _____
_____
_____

Date Diagnosed: _____
General Prognosis:_____
_____

MEDICAL CONTACTS

The following information is necessary, so that we may verify your condition

	Physician	**Social Worker**
Name		
Address		
Phone		

INSURANCE
If Applicant has Health Insurance, Medicare, or Medicaid please specify _____
_____

SOURCES OF INCOME
The following financial information is used to determine applicant's need for help. It will be shown only to the Board of Director's of NewDay Foundation and will not be otherwise disclosed. Additional information may be requested at the discretion of the NewDay Foundation Board of Directors.

How many people are currently living in your household? _____

List current sources of income for yourself and for other members of your household:

	Applicant	Spouse/Other Household Members
Wages		
Social Security		
Disability Income		
Other		
Total Income per year		

RESIDENCE

Do you or your family OWN _____ or RENT _____ the home in which you live?
If owned, what is its present Value? $_____ What is the current mortgage balance $_____
What is the monthly rental or mortgage payment? _____

OTHER ASSISTANCE FOR WHICH APPLICANT HAS APPLIED

If applicable, describe the following assistance, for which you have applied:

1. Health insurance (list insurer) _____

2. Medicare/Medicaid _____

3. Fuel assistance, Social Security Disability, aid from Welfare Office, aid from the Veteran's Administration _____

4. Other _____

Please mention any other facts you would like us to consider while discussing your request (attach a separate sheet if needed)

ASSISTANCE OR RESOURCES REQUIRED

List the types of financial assistance or resources you seek :

_____

_____

If someone other than the applicant is submitting this application, please complete the following:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Relation: _____

Name and contact information of a person NewDay Foundation should contact if we have questions concerning arrangements for distributing funds:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Relation: _____

Other Support

Please check all other services you are interested in.

- Online Support
- Educational Programs/Materials
- Referrals to other resources
- Transportation

General Release

I/We wish to participate in the benefits provided by the NewDay Foundation of La Porte, Inc.

I/We understand that our participation in such a program is wholly voluntary and that these benefits are provided by "NewDay Foundation" in furtherance of its humanitarian endeavor oto provide financial support to La Porte area residents who are battling cancer without the assistance of health insurance and/or who are in financial difficulties or in need of other assistance. I/We understand that we have not been given any assurance of benefits/assistance.

I/We hereby assume all risks and responsibility for any damages or injury (including the aggravation of any existing illness or condition), which we or our family may sustain as a result of our participation in the benefits provided by the "NewDay Foundation," its officers, directors, agents, sponsors, medical advisors, volunteers, and employees.

I/We hereby release, discharge, indemnify and agree to hold harmless "NewDay Foundation," its officers, directors, agents, sponsors, medical advisors, volunteers, and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from arising out of, or incidental to our participation in the programs or benefits provided by "NewDay Foundation."

In Witness thereof this _____ day of _____, Year _____

Signed: _____ Witness: _____

Authorization for Release of Medical or Hospital Records And/or Disclosure of Medical Information

I am requesting financial assistance from the NewDay Foundation of La Porte, Inc. in obtaining medication, supplies, help with living expenses or Medical costs. To that extent, I hereby authorize my Doctors and/or Hospitals to provide any needed information the NewDay Foundation of La Porte may need to assist in determining my eligibility to receive such financial assistance.

I understand that NewDay Foundation will utilize the information received in order to assist in evaluating my need and providing assistance, and that this use may include maintenance of this information as a part of NewDay Foundations internal records, or disclosure to other charitable organizations (including but not limited to the Unity Foundation) in an effort to assist me in obtaining aid. I hold NewDay Foundation harmless as to any inadvertent disclosure of information done in good faith.

_____ _____

Signature Date

_____

Print Name