Family Support Gift Card Program 2016

Application Information

Providing support to families affected by pediatric brain cancer is one of Joshua's Great Things missions. We are happy to be able to give families the opportunity to apply for a gift card through our gift card program. Please review the application requirements listed below and complete the Family Support Application, along with required signatures.

Joshua's Great Things has a limited amount of funds available for family support and we will send the requested option based on availability. Applications are reviewed by our Finance Committee approximately every two weeks. You will be contacted by Joshua's Great Things following review of your application. We will do our best to honor your request and provide you with the best support to meet your needs.

Family Support Requirements

1. Any family with a child diagnosed with brain cancer prior to the child's 18th birthday **and** be in active cancer treatment is eligible for consideration.
2. The applicant must be the parent or legal guardian of the diagnosed child and the primary caregiver of the child.
3. All sections of the application must be completed and signatures must be on the form in order for our Finance Committee to review the request. Failure to provide complete information is a basis for denial of an application.
4. Assistance may be requested once each calendar year. Each request for assistance requires submission of a new application.
5. Please contact Rhonda Brown at joshuasgreatthings@gmail.com if you have any questions concerning the application process.

After you complete the application, please return it to your hospital social worker,
scan and e-mail, or mail to:

Joshua's Great Things
PO Box 114
O'Fallon, IL 62269
joshuasgreatthings@gmail.com

Joshua's Great Things

Application Date: ____________________

Family Support Application 2016

Section 1: Patient and Family Information

Patient's Name: ____

Birth Date: ___________________________ Gender: ________

Address: _____________________________ City: _______________ State: _____ Zip: _________

Home Phone: ______________________________ Cell Phone: _____________________________

Email Address: ____

Name of Parent(s)/Guardian(s): ____

How did you hear about our program: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ Family/Friend

Patient's Diagnosis: ____

Date of Diagnosis: ______________ Is patient in active cancer treatment ? ☐ Yes ☐ No

Treating Physician Name: _________________________ Hospital/Clinic: _______________________

Section 2: Medical Information and Provider Certification

(To be completed by the patient's treating Physician, Social Worker, or designee.)

I certify that the information in the application is true and accurate, to the best of my knowledge.

Health Care Professional Name: ____

Health Care Professional Signature: ____

Section 3: Family Support Options

For 2016, families will receive $150 in gift cards. Please, choose the gift card option that would be most beneficial to your family - you may choose to have your support split between up to three options.

☐ BP Gas	☐ Schnucks	☐ Applebees
☐ Shell Gas	☐ Dierbergs	☐ Pizza Hut
☐ Circle K	☐ Walmart	☐ McDonalds
☐ Moto Mart	☐ Target	☐ St Louis Bread Co

Section 4: Parent Signature and Agreement

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate. Also, by signing this application I give the medical professionals listed above and Joshua's Great Things permission to discuss medical information about my child's case.

Patient Name: ____

Parent/Guardian Signature: ________________________________ Date:_______________