

CJs Thumbs Up Foundation



Application for Financial Assistance

YOU MUST FILL OUT THE APPLICATION COMPLETELY AND MEET ALL REQUIREMENTS IN ORDER TO BE CONSIDERED FOR A FINANCIAL AWARD; PLEASE PRINT OR TYPE CLEARLY

Applications will be processed in the order in which they are received. Funds are distributed on a quarterly basis in February, May, August, and November. Qualified applicants will receive funds and/or notice of application status by the end of each month when funds are distributed. If funds are not currently available, you will be placed on a waiting list. **You do *not* need to reapply if you are placed on a waiting list.**

Completed applications should be mailed to: CJSTUF PO Box 854 Ashland, VA 23005

For questions regarding your application or the CJ's Thumbs Up Foundation, please contact us at:

Phone: 804-798-7522 Email: info@cistuf.org Web: www.cistuf.org

Child's Information

Full Name: _____

Date of Birth: _____ Male Female

Child's Primary Diagnosis: _____

Date Diagnosed: _____ Child being seen by physician at Children's Hospital of Richmond/MCV

Family Information

Mother/Guardian Full Name: _____

Address: _____

Email address: _____

Primary phone: _____ home cell

Secondary phone: _____ cell other

Father/Guardian Full Name: _____

Address: _____

Email address: _____

Primary phone: _____ home cell

Secondary phone: _____ cell other

Child lives with both parents mother father shared custody (two households) guardian

Other (please specify) _____

Total Number of children in household _____

How did you hear about CJSTUF?

social worker hospital professional friend internet Other _____

For internal use only

Postmark date ____ Application number _____ Date Reviewed _____ Date funds distributed _____

Medical Information

Physician: _____ Phone number: _____

Physician Address: _____

Social Worker: _____ Phone number: _____

Primary hospital or clinic: _____

Statement of need

(may be completed by parents, licensed medical professional, and/or social worker)

Please complete a brief statement of need, summarizing the child's current diagnosis and course of treatment as well as the primary reason for the request for financial assistance from CJSTUF.

Physician verification

By my signature, I verify that the applicant has been diagnosed with a chronic and life threatening condition as listed within the application and that s/he is currently undergoing treatment for this condition under my care.

Physician Signature: _____ Date: _____

Physician name (Please print): _____

Application submitted by Parent/Guardian on _____

(date)

Parent/Guardian Signature _____

Media Release

I hereby give my permission for CJ's Thumbs Up Foundation (CJSTUF) and/or its representatives to use photographs, audio/video recordings, letters, and information about my child or my family and to use our names, information, pictures, or voice recordings in publications, media presentations, motion pictures, or on the Internet. I understand that these publicity materials will be used to inform families, volunteers, media, and the general public about CJSTUF and its programs, services, or events. I gladly give this authorization to support the efforts of CJSTUF. I understand that this authorization shall continue until terminated in writing.

****Signing the media release is not a requirement in order to receive assistance from CJSTUF****

Child's name (print) _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian print name _____

Address _____