Cameron's Crusaders

Application for Assistance

Cameron's Crusaders Corp. is a non profit organization, which is dedicated to assisting children and their families of the New England region who are battling medical issues, and who lack sufficient health insurance and/or financial resources.

Send completed application to:
Cameron's Crusaders
64 Putnam Park, Fitchburg MA, 01420
If you have questions, contact us at (802) 881-8316

IMPORTANT!

You must sign the releases on pages 5, 6 & 7 before sending us this application.
All information is strictly confidential

Cameron's Crusaders Application for Assistance

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

NOTE: All information will be kept strictly confidential.

Application Date: _____/_____/_____
MM DD YY

Applicant Name: _____

Age: _____ Date of Birth: _____/_____/_____ Male _____ Female _____
MM DD YY

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Mailing Address: _____

City: _____ State: _____ Zip:_____

Phone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Cell: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Physical Address _____
if different from mailing address _____
_____

Patient name: _____

ILLNESS Diagnosis_____

Date Diagnosed _____/_____/_____ General Prognosis_____
MM DD YY

MEDICAL CONTACTS The following information is necessary, so that we may verify condition:

Physician _____ Social Worker _____

Address _____ Address _____

_____ _____

Phone ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ 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 Directors of Cameron's Crusaders Corp., and will not be divulged to anyone else. Additional information may be requested at the discretion of Cameron's Crusaders 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 $ _____

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 the Town 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

_____

_____

_____

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

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Cell: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Relation:_____

Name and contact information of person Cameron's Crusaders should contact if we have questions concerning arrangements for distributing funds:

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Cell: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Relation:_____

Type of assistance that you are applying for:
Check all that apply:

Gas Card ___	Grocery Card ___	Heat Assistance ___
Lodging ___	Electric Bill ___	Child care___
Parking ___	**Housing ____	Repairs ___
*Medical ___	Equipment ___	***Modifications ___

Other ____

All items checked may not be awarded a disbursement by the board

*** Medical - defined as copayment for Dr./ER visits, prescriptions not covered by insurance, ancillary medical cost.**
**** Housing - defined as Mortgage or Rent payment**
***** Modifications - defined as modifications to house or apt. to accommodate ADA**

General Release

I/We wish to participate in the benefits provided by Cameron's Crusaders Corp..

I/We understand that our participation in such a program is wholly voluntary and that these benefits are provided by “Cameron’s Crusaders Corp.” in furtherance of its humanitarian endeavor to provide financial support to New England area children and their families who are battling medical issues without the assistance of health insurance and/or who are in financial difficulties.

I/We hereby assume all risks and responsibility for any damage 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 “Cameron’s Crusaders Corp.,” its officers, directors, agents, sponsors, medical advisors, volunteers, and employees.

I/We hereby release, discharge, indemnify and agree to hold harmless “Cameron’s Crusaders Corp.,” 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 “Cameron’s Crusaders.”

In Witness thereof this _____ day of _____, Year _____

Signed: _____

Court certified documentation granting Legal Guardianship, POA, or other authority to act on behalf of a minor is required.

Witness: _____

Authority to Release Hospital Records and/or Divulge Medical Information

1. PRIMARY CARE PHYSICIAN: _____

Address: _____

_____

In regard to your patient named:

_____

Age: _____ DOB: _____/_____/_____
MM DD YY

You are hereby authorized to furnish and release to [1]Cameron's Crusades Corp. all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ Date: _____/_____/_____
[2]Parent or Guardian (or adult with authority to act for minor) MM DD YY

Witness:_____ Date: _____/_____/_____
MM DD YY

2. HOSPITAL: _____

Address: _____

_____

In regard to your patient named:
_____

Age: _____ DOB: _____/_____/_____
MM DD YY

You are hereby authorized to furnish and release to [1]Cameron's Crusaders Corp. all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ Date: _____/_____/_____
[2]Parent or Guardian (or adult with authority to act for minor) MM DD YY

Witness:_____ Date: _____/_____/_____
MM DD YY

Authority to Release Hospital Records and/or Divulge Medical Information continued

3.OTHER:_____

Address:_____

_____

In regard to your patient named:

_____

Age: _____ DOB: _____/_____/_____
MM DD YY

You are hereby authorized to furnish and release to [1]Cameron's Crusaders Corp. all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ Date: _____/_____/_____
[2] Parent or Guardian (or adult with authority to act for minor) MM DD YY

Witness:_____ Date: _____/_____/_____
MM DD YY

[1] Cameron's Crusaders Corp. is a non-profit organization, which provides non-medical supplemental financial assistance to children and their families battling medical issues in the New England region.

[2] Court certified documentation granting Legal Guardianship, POA, or other authority to act on behalf of a minor is required.