



Application for Assistance

CONFIDENTIAL

To be considered for assistance through the Woo Who Foundation, please make sure all sections are completed and all required signatures are included. Send the completed application to:

Woo Who Foundation
32406 Brandon Place
Avon Lake, Ohio 44012

Personal Information

Applicant's Name:

First

Middle

Last

Street Address: _____

City, State, Zip: _____

Age: _____

Date of Birth: _____

Home Phone: _____

Race (Optional): _____

Work Phone: _____

Best Time to Call: _____

Email Address: _____

Referred by: _____

Personal and Family Information

Marital Status (check one) Single Married Widowed Partnered
 Separated Divorced

Children or Dependents living in your home and ages:

_____	_____	_____	_____
_____	_____	_____	_____

Employment Status:

Current Employment/Occupation: _____

Employer Address: _____

Work Status (full-time, part-time, retired, disability, leave of absence, etc.): _____

Monthly income (include pension, social security, alimony, etc.): _____

Spouse/Partner Employer: _____

Employer Address: _____

Work Status (full-time, part-time, retired, disability, leave of absence, etc.): _____

Monthly income (include pension, social security, alimony, etc.): _____

Additional Persons Employed in the Household: _____

Employer Address: _____

Work Status (full-time, part-time, retired, disability, leave of absence, etc.): _____

Monthly income (include pension, social security, alimony, etc.): _____

Medical Information

Please attach a copy of your pathology report for verification purposes. Application can not be reviewed without this information.

Physician's Name: _____

Facility: _____ Phone: _____

Nurse/Social Worker: _____

Facility: _____ Phone: _____

Health Insurance:

_____ Private/Employer Insurance (Level of deductible: \$_____)

_____ Medicaid _____ Medicare _____ Disability Insurance _____ None

Public or private assistance you may be receiving, additional insurance information that may help in processing your application: _____

Other Assistance:

Have you received assistance in the past from the Woo Who foundation or are you currently receiving grants or aid from other organizations with similar missions to the Woo Who Foundation? _____ Yes _____ No

If yes, please indicate the organization and the amount of grant received:



Medial Record Release and Authorization

Ohio and Federal law protect the privacy and confidentiality of an individual patient's medical records. In order for the Woo Who Foundation to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be executed and submitted to your health care provider(s). Please note that you are afforded the following rights with respect to the Release and Authorization:

- You may refuse to sign the Release and Authorizing Form, although you will then be ineligible to receive financial assistance from The Foundation.
- You may revoke the Release and Authorization by submitting a written revocation to the health care provider.
- The revocation will be effective upon receipt by the healthcare provider.
- You have the right to receive a copy of this Release and Authorization upon written request.
- You may inspect or obtain copies of all information which the Foundation receives pursuant to this Release and Authorization.

Name: _____ DOB: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____ SSN: _____

I hereby authorize _____

(Health Care Provider)

to release all health care and billing information regarding my treatment to the Woo Who Foundation at 32406 Brandon Place, Avon Lake, Ohio 44012.

I specifically authorize the release of all my health care and billing information to your organizations possession. The purpose of this request is to assist the Woo Who Foundation in determining my eligibility for financial assistance.

This Release and Authorization shall expire twelve (12) months from its execution if not revoked prior thereto. The Foundation will not disseminate or release your medical record to any outside source without first obtaining your prior express consent.

Signature of Applicant

Date



Publicity Release

The Woo Who Foundation is a non-profit organization devoted to providing a service to the Breast Cancer Community. Whether it's supporting a woman through the trials of breast cancer, aiding the families of those women who continue to fight or have lost their battle with Breast Cancer, or supporting causes that promote the fight for a cure. Our goal is to host a number of fundraisers and events throughout the year in order to grow a fund to benefit several local families in need.

Anchored by our annual UrbanObstacle and a series of other events that support the foundation financially, all of our events focus on enjoying life and having a good time. In our minds, fundraising is a celebration of those that we've lost and miss dearly, a celebration of those that continue to fight and inspire us daily, and a celebration of community spirit and goodwill.

We need your help to put a face and a name to that reality.

We ask for your permission to use your photo, your story, and a brief description of how the money you received from The Foundation has helped you. This will assist us in communicating to our donors and help in attracting more contributors so we can do more. Please indicate your permission by checking the appropriate areas:

_____ Use of photo (Include Photo)

_____ Your background information

_____ Your name

_____ Your story

_____ NO, I prefer that the Woo Who Foundation not use my personal information in their publicity efforts and wish to remain anonymous. I understand this will not in any way exclude me from receiving assistance.

Permission to use the checked information above is given to the Woo Who Foundation for use in PR and Marketing materials which will include, but not be limited to, their Annual Report, Newsletter and Website.

Signature of Applicant

Date



Application Release and Authorization

Please read and sign below. Make sure to have your signature witnessed and dated.

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of the Woo Who Foundation regarding the assistance I am requesting.

I understand and grant permission to all my doctors, clinics and hospitals to provide the Woo Who Foundation relating to treatment and care for breast cancer and other related health problems when necessary. The Foundation agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission.

I understand and agree that fulfillment of assistance may result in publicity whether or not the Woo Who Foundation actively takes steps to publicize its service.

I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by the Woo Who Foundation.

I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of services being requested and offered.

Participant

Date

Witness

Date

Please mail the complete application to:

**Woo Who Foundation
32406 Brandon Place
Avon Lake, Ohio 44012**

www.woowhofoundation.com