Application for Sy's Fund, Inc.

Sy's Fund is a fund for young adults ages 18-39 with cancer or serious ongoing medical issues stemming from cancer. We fund meaningful gifts and integrative therapies. We do not provide general financial assistance. For questions or concerns regarding what types of things we fund or regarding information we need to process your application, please call Sy's Fund at 413-512-9177 or email us at sysfund@gmail.com

Please send completed application to: ***Sy's Fund, P.O. Box 3549, Ramona, CA 92065***

Name _____

Address _____

City_____ State_____Zip _____

Date of birth _____

Phone ( ) _____

Email address (optional) _____

Name of Alternate Contact:_____ Phone/Email:_____

Sy's Fund would like your permission to share information in order to continue helping others. This could include things like sharing a quote from you on our website or Face Book page, or during fundraiser events for example. We do not share your information with other organizations.

Sharing of information is voluntary, except as needed to determine eligibility and provide funding. If you prefer that we do not share your information it will in no way preclude you from receiving assistance from Sy's Fund

☐ I GIVE PERMISSION FOR SY'S FUND TO USE MY NAME & INFORMATION

☐ I GIVE PERMISSION FOR SY'S FUND TO USE MY INFORMATION BUT WISH TO REMAIN ANONYMOUS.

☐ I GIVE PERMISSION FOR SY'S FUND TO USE THE FOLLOWING INFORMATION ONLY:

_____

☐ SHARE MY INFORMATION ONLY AS NEEDED TO PROCESS MY APPLICATION & PROVIDE FUNDING

_____ _____

SIGNATURE OF APPLICANT ***DATE***

CHECK LIST OF ADDITIONAL DOCUMENTATION WE WILL NEED TO COMPLETE YOUR APPLICATION:

- ✓ **Copy of drivers license or other photo ID (state photo ID, college/school photo ID) (can be sent through email, fax, or through mail with application)**
- ✓ **Medical release filled out by Oncologist/Oncology Social Worker or Registered Nurse Practitioner (we need original release: please mail with application)**
- ✓ **Release for integrative therapist if applicable**
- ✓ **Brief letter telling us a bit about yourself and what you would like us to fund**

PLEASE EMAIL OR CALL SY'S FUND IF YOU HAVE ANY QUESTIONS REGARDING INFORMATION NEEDED:

EMAIL: sysfund@gmail.com

PHONE: 413-512-9177

Website: www.sysfund.org

SECTION I: MEDICAL RELEASE OF INFORMATION

To be completed by Physician, Oncology Social Worker or Nurse Practitioner

1. Your professional role (*check one – only professionals in roles listed here may complete this verification form*):

□ Physician □ Oncology Social Worker
□ Nurse Practitioner

2. Name of Patient:_____Patient's Date of Birth _____

3. Patient's diagnosis _____

4. Date of diagnosis_____

5. Current treatment _____

6. Any ongoing medical issues related to treatment or cancer_____

_____

_____

7. How long have you been treating this individual? _____

8. I currently see this individual:
□ daily □ weekly □ monthly □ other (specify) _____

Signature of professional:_____Date: _____

Please print:

Name:_____Title: _____

Address:_____Phone: _____

PLEASE SEND ORIGINAL WITH APPLICATION TO SY'S FUND
KEEP COPY FOR YOUR RECORDS

SECTION II: MEDICAL RECORDS RELEASE **(to be completed by patient)**

I authorize the professional identified in Section I to release the information requested on this form to Sy's Fund. I also authorize professional to speak to representative from Sy's Fund to verify information if needed.

Patient's signature:_____ Date: _____

Please print:

Patient's name:
_____

Address:
_____

Phone: _____

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SY'S FUND
P.O. Box 3549
Ramona, CA 92065

PHONE: 413-512-9177

INFORMATION & RELEASE FOR INTEGRATIVE THERAPIST

To be completed by Professional providing treatment

1. Professional role/treatment you provide:
   - ☐ Acupuncturist
   - ☐ Massage Therapist
   - ☐ Reflexologist
   - ☐ Reiki Practitioner
   - ☐ Cranial Sacral Practitioner
   - ☐ Chinese Medicine Practitioner
   - ☐ Other: _____

2. Name of Person being treated: _____

3. I currently see this individual:

☐ daily ☐ weekly ☐ monthly ☐ other (specify frequency) _____

4. Payment per treatment: $_____

Signature of professional:_____Date: _____

Please print:

Name:_____Title: _____

Address:_____Phone: _____

Please attach copy of license or certificate to release form.

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For more information contact: Sy's Fund at 413-512-9177

http://www.sysfund.org sysfund@gmail.com

INTEGRATIVE THERAPY RELEASE **(to be completed by patient)**

I authorize the professional identified in "Information and Release For Integrative Therapy" to release the information requested to Sy's Fund.

Patient's signature:_____Date: _____

Please print:

Patient's name:
_____

Address:
_____

Phone: _____

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