"Helping Kids in Need… One Smile at a Time"

One of the objectives of the Addison Jo Blair Foundation is to assist families of children with cancer who are being treated at Norton Children's Hospital. Upon approval, the Foundation can provide needs assistance for gas, food, and other basic necessity items that directly benefits the child while minimizing some of the financial burden attributed to the child's illness.

Application for Needs Assistance

(Please Print)

Child's Name:____

SSN: ______________________DOB: ______________________ Gender:___________________________

Parent/Legal Guardian Name:____

Address:____

City:__________________________State:________________________Zip Code:______________________

Phone:___________________________________ Cell Phone:_______________________________________

Email Address:____

Annual Household Income:____

Have you applied to the AJB Foundation before?_________(Y/N) If YES, when?_________________________

Are you currently receiving any other financial/needs assistance via the government or other non-profit organizations?

_________ (Y/N)

If YES, please provide what type and specified amount____

Needs: List in order from **greatest** to **least** the following needs: Gas; Food; Other Needs Items (toiletries, clothing etc.)

1. ________________________ 2. ___________________________ 3. ____________________________

*****Please note: In order for your application to be reviewed, you must submit the following items:***

- Application for Needs Assistance
- Your child's medical information completed by medical professional at Norton Children's Hospital

Parent/Legal Guardian:____ Date:___________________

By signing this application, you are agreeing to allow your child's name and medical condition to be released to the Addison Jo Blair Foundation in order to grant possible financial assistance to your family.

Addison Jo Blair Foundation
167 Tattersaul Dr.
Elizabethtown, KY 42701
info@addisonjoblair.org

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MEDICAL STATEMENT FOR ELIGIBILITY

(To be Completed by Medical Professional)

Child's Physician at Norton Children's Hospital:____

Child's Diagnosis: ____

Date of Diagnosis:______________________ **Currently in ongoing treatment, maintenance therapy? (Y/N)**__________________

NCH Oncology Department Address: ____

City: ____ **State:** ___________ **Zip Code:** ___________________________________

Phone: ___________________________ **Email (Optional):** ____

Please briefly describe the child's medical condition and anticipated length of treatment plan and/or protocol:

(Attach additional documentation if necessary)

____ ____

Name and Title of Medical Professional at NCH
(Please Print)

Signature of Medical Professional at NCH

Parent/Legal Guardian:____ **Date:**____________________

By signing, you are agreeing to allow your child's name and medical condition to be released to the Addison Jo Blair Foundation in order to grant possible needs assistance to your child and family.

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