BACK Fighting Cancer, Inc.'s primary mission is to provide financial assistance to families in Levy, Dixie and Gilchrist Counties with a child fighting cancer.

Each letter in **BACK** represents the first initial of the name of a local child who either battled or is battling some form of cancer. **B**=Bridget **A**=Austin **C**=Corbin **K**=Kendall – each family benefited from the love and support of our communities in our darkest times. Each family is represented on the Board of Directors and now we are giving **BACK**!!

To apply for assistance please complete the application and return it to your social worker. When your application is approved, someone from **BACK Fighting Cancer, Inc.** will contact you via email and/or telephone. **PLEASE** make sure you provide accurate contact information.

Your information will NEVER be sold or given to anyone without your permission.
If you have any questions regarding this application, you may contact **BACK Fighting Cancer, Inc.** at (352) 356-8518 or via email at **info@BACKFightingCancer.org**.

Application Guidelines:

1. The patient must be 18 years of age or younger and be currently undergoing treatment for a cancer-related diagnosis.

2. Submit completed application through hospital or physician representative (i.e. social worker, doctor or hospital administrator to **BACK Fighting Cancer, Inc.**, Post Office Box 1419, Old Town, FL 32680.

3) Patient **MUST** reside in Levy, Gilchrist or Dixie Counites. Proof of Address is required (***Copy of Drivers License and/or Utility Bill***)

4) Complete all sections of the applications truthfully. Any false, incomplete or misleading information will result in application denial.

APPLICATION FOR ASSISTANCE

Parent or Guardian's Name: ______________________________

Parent/Guardian Email: ______________________________

Daytime phone: ______________________________

Child's Name: ______________________________Age:__________

Mailing Address: ______________________________

____

Physical Address (if different than above): ______________________________

____

Diagnosis: ______________________ Date of diagnoses: __________

Where is child being treated? ______________________________

Lead Physician: ______________________________

How long is approximate length of treatment for your child? ______________

Hospital Rep: ______________________________

(Social worker) Name: ______________________________

Hospital Rep Email:______________________________

Hospital Rep Daytime Phone______________________________

By signing this application I agree that all information submitted is current and accurate. I also understand that there are no financial aid guarantees. I agree to allow **BACK Fighting Cancer, Inc.** to discuss my child's case with hospital/medical professionals to determine eligibility.

______________________________ ______________

(Parent/Guardian) Signature Date

____

Print Parent/Guardian Name

Office Use Only

Date Application Received ______________ Date Approved______________

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____

Date of Birth: ____

Previous Name: ____

Social Security #:____

I authorize **BACK Fighting Cancer, Inc.** to release healthcare information of the patient named above for use on their website and in other media outlets. The information may be released (in addition to through the website), through press releases, flyers, images and may be in print, photography and video.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

____

____

☐ All healthcare information

☐ Other: ____

____

_______________________________ _______________

(Parent/Guardian) Signature Date

____

Print Parent/Guardian Name

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS THE PATIENT OR HIS OR HER PARENT REVOKES THE AUTHORIZATION IN WRITING.

PARENT RELEASE FORM FOR MEDIA USE

I, the undersigned, do hereby grant permission to **BACK Fighting Cancer, Inc.** to use the image of my child, ____. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the **BACK Fighting Cancer, Inc**.
website.

☐ Unrestricted usage: I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by **BACK Fighting Cancer, Inc.** for a variety of purposes and that these images may be used without further notifying me. I grant this permission on behalf of my minor child for perpetuity.

____ ______________

(Parent/Guardian) Signature Date

____

Print Parent/Guardian Name