Chad Milliken Memorial Fund
www.cm-mf.com

Financial Support Application:

Full Name: _____

Date of birth: _____

Street Address: _____

Email Address: _____

Best number & time to reach you: _____

Current Diagnosis: _____

Date of Diagnosis: _____

Stage/Grade: _____

Actively receiving treatment? Yes ☐ No ☐

If yes, please provide where you are receiving treatment from and the name of your Oncologist which whom we may contact if necessary (also complete HIPPA release form):

Location	Oncologist Name	Email/Phone:

Tell us a little bit about yourself (optional):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Provide brief explanation of the type of expenses you are looking to get assistance for:

_____
_____
_____
_____
_____
_____

Please read these items carefully and check the boxes that are true:

- ☐ I understand the Chad Milliken Memorial Fund does not cover any medical expenses
- ☐ I currently have a diagnosis of a brain tumor or am a family member applying on their behalf
- ☐ I understand the Chad Milliken Memorial Fund may need to ask personal questions about my diagnosis and treatment; I agree to provide accurate answers.
- ☐ I give full authorization to the Chad Milliken Memorial Fund to obtain the necessary medical information to process my application.

I give the Chad Milliken Memorial Fund the permission to share the following on Social Media about the donation received:

- ☐ First Name
- ☐ Diagnosis
- ☐ Where you are receiving treatment
- ☐ What the funds will be used for
- ☐ Any other personal details (as provided by you) that you'd like shared:_____

_____
_____
_____
_____
_____

I have read and confirm that the information provided on pages 1 and 2 of this application are accurate:

Signature:_____ Date: _____

Please email your completed application and signed HIPPA form to contact@chadmillikenmemorialfund.com

Our Mission: To provide financial flexibility to allow the patient and their families some peace of mind and the ability to spend time where it really matters: On the fight, and with the fighter.

HIPPA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164).

1) **Authorization**
   I _____ (print name) Authorize _____
   (your treating physician) to disclose the protected health information described below to the Chad Milliken Memorial Fund.

2) **Effective Period**
   This authorization for release of information covers the period of healthcare from _____ (Date) to and through _____ (Date).

3) **Extent of Authorization**
   I authorize the release of my health record only as it pertains to my brain tumor diagnosis and treatment.
4) This medical information may be used by the Chad Milliken Memorial Fund for the purposes of evaluating my eligibility for receiving financial support.
5) This authorization shall be in force and effect until _____ (date), at which time the authorization expires.
6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7) I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative:

_____ _____

Signature **Date**

_____

Please Print Name