Miracles for Mya

Miracles for Mya Assistance Application

www.MiraclesforMya.org

Assistance may be provided on individual needs determined after speaking with a Miracles for Mya representative. Help will be provided if criteria are met. Support is based on individual needs to accessing care and available resources. Just like every diagnosis is different, so are the needs of those families fighting cancer.

Please anticipate up to 2-4 weeks for the application process.

Eligibility Requirements:

1. Patient must reside in Illinois.
2. Patient must be age 18 or under.
3. Assistance must be for **current** cancer treatment. Active treatment is defined as in surgery and follow-up to surgery, radiation, and/or chemotherapy. Assistance will not be provided retroactively for completed cancer treatment.
4. **Healthcare provider (physician, nurse, social worker, etc.) must sign the patient's application form and include a letter affirming that the patient is currently receiving cancer treatment.**
5. Application form must be completed in full and submitted to the address below or it will be returned. Assistance will not be received without the direct knowledge of the patient.

X_____ PLEASE INITIAL ACKNOWLEDGING UNDERSTANDING OF THE ABOVE STATEMENTS

PRINT CLEARLY! ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS APPLICATION.

Application Date ________________________

Name ____

Address ____

City ________________________________ **State** _____________ **Zip Code** ______________

Home Phone (___) _______________ **Work (___)** ______________ **Cell (___)** _____________

Email address ____

Date of Birth ____________________________ **Last 4 digits of SSN** ____________________

Gender: Male □ Female □ Age _________ **Siblings in the home Y/N Ages** _______________

Diagnosis ____

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Race/Ethnicity: White/Caucasian □ African American □ Hispanic/Latino □
Native American/American Indian □ Asian American/Pacific Islander □
Other (specify) _______________________________

Health Insurance Information:

Do you have health insurance?
Yes □ No □

If yes, please indicate type of insurance (check all that apply):
Medicaid □ **Medicare** □ **Private Insurance** □ **COBRA** □ **Charity Care** □
Supplemental Insurance □ **Other** ____

If no, have you applied for Medicaid? Yes □ No □

Are your prescription drugs covered? Yes □ No □

How did you find out about Miracles for Mya? ____________________________________

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Signature ____ Date _______________

Please mail completed application to:
Miracles for Mya
P.O. Box 3747
Joliet, IL 60434