# 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 must include a photocopy or picture of parent/legal guardian's Driver's License or State ID.** □
6. 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 ___/___/____ Patient Name _____**
**Parent/Guardian Name & Relationship _____**
**Address _____**
**City _____ State _____ Zip Code _____**
**Home Phone (___)_____ Work (___)_____ Cell (___)_____**
**Email address _____**
**Parent/Guardian's Driver's License/State ID# _____**
**Patient Date of Birth ___/___/____ Patient Gender: Male □ Female □ Age _____**
**Siblings in the home Y/N Ages _____**
**Date of Diagnosis ___/___/____ Diagnosis _____**
**Hospital/Facility of Treatment _____**
**Name of Physician/Nurse Practitioner _____**
**Name of Social Worker _____**

**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 hear about Miracles for Mya? _____

Please share the type of assistance you're seeking:

**Gift Cards**:
Mariano's □ Aldi □ Jewel □ Meijer □
Walgreens □ CVS □ Target □ Sam's Club □
Speedway □ Shell □ Walmart □ Amazon □
Other (please specify) _____

**Toys/Gifts:**
Ideas or specific 'wants' _____
_____

Any additional information about the patient you care to share? _____

Parent/Guardian Signature _____ Date ___/___/_____

Print Name & Relationship _____

Healthcare Signature _____ Date ___/___/_____

Print Name & Title _____

Please mail completed application to:
**Miracles for Mya**
**P.O. Box 3747**
**Joliet, IL 60434**
**-OR-**
**Email: miraclesformya@gmail.com**


# Miracles for Mya Photography/Social Media Authorization Release Form

www.MiraclesforMya.org

I hereby grant to Miracles for Mya the irrevocable and unrestricted right to use and publish photographs of me, or in which I may be included, for library publications, electronic reproductions (websites) and/or promotional materials or any other purpose and in any manner or medium. In addition, I grant my permission to alter the same without restrictions; and to copyright the same. I hereby release the photographer and Miracles for Mya from all claims and liability relating to said photographs.

Print Patient Name: _____ Date: ___/___/____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Phone: _____

For persons under the age of 18:

I, _____, am the parent/legal guardian of the individual named above; I have read this release and approve of its terms.

Print Name: _____ Date: ___/___/____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Phone: _____

Please mail completed application to:
**Miracles for Mya**
**P.O. Box 3747**
**Joliet, IL 60434**
**-OR-**
**Email: miraclesformya@gmail.com**