NORTH VALLEY
SPARROW
FOUNDATION

Application for Assistance

Patient Last Name: _____

Patient First Name: _____

Patient Middle Name/Initial: _____

Patient SSN: _____

Patient Date of Birth: _____

Present Physical Address: _____

County: _____

Present Mailing Address: _____

Home Phone: _____

Cell Phone: _____

Message Phone: _____

Email: _____

Full Name of Applicant/Caregiver (If Different than Patient): _____

Applicant Relationship to Patient: _____

Employer (Of caregiver/guardian if patient is a minor):_____

Diagnosis: _____

Diagnosis Date: _____

Treatment Protocol (Chemo, Radiation, Transplant, etc.):_____

_____

Treatment Location (Name, Address, Phone Number):_____

_____

_____

How Many Times a Month is Treatment Received?:_____

Current Treatment Status (Newly diagnosed, Treatment in progress, Remission, Etc.):

_____

Physician Information (Name, Address, Phone):_____

_____

Government Assistance Received as Patient/on Behalf of Patient (Social Security, Food Stamps, Government Cash Aid, etc,): _____

_____

_____

Total Monthly Government Assistance Amount Received: _____

Do you have a GoFund me account, or other similar fundraising account for you/patient?: _____

If so, how much?: _____

Please list all family members responsible for patient care:

1.Name, Relationship to Patient, Age: _____

_____

2.Name, Relationship to Patient, Age: _____

_____

3.Name, Relationship to Patient, Age: _____

_____

North Valley Sparrow Foundation provides families we serve in Northern California rural communities with pre-paid gas cards, pre-paid grocery/restaurant cards, help with payments for utilities, rent/mortgage, car repairs/tires, traveling, & lodging, medical treatments/supplies and alternative treatments not covered by insurance, and emotional support services for patients and caregivers. No cash payments will be distributed directly to recipient. All monetary funds will be paid directly to third party vendors on behalf of patients and their caregivers.

FINANCIAL ASSISTANCE WILL NOT BE DISTRIBUTED IN BULK MONETARY AMOUNTS UNLESS BY SPECIAL BOARD APPROVAL. ALL FINANCIAL ASSISTANCE WILL BE DISTRIBUTED ON A CASE BY CASE BASIS, BASED ON URGENCY, CONSIDERED IN THE ORDER IN WHICH REQUESTS ARE RECEIVED. PLEASE NOTE, A REQUEST FOR FUNDS IS IN NO WAY INDICATIVE OF GUARANTEED RECEIPT OF FUNDS. North Valley Sparrow Foundation strives to serve as many families as possible, noting that fund availability fluctuates throughout the year.

THE FOLLOWING SECTION MUST BE COMPLETED TO BE CONSIDERED FOR A DONATION.

Requested Monetary Amount:_____

Contact Information for Bills to be Paid (Ex: Landlord, Utility Company, Physician, etc.): _____
_____
_____
_____

Account # for Vendor(s) if Applicable:
_____

Photo copy of statement/bill to be paid (Circle if applicable): Please include documents to support requests such as bills, invoices, statements, lease agreements, etc. Also, please prioritize your request(s) in order of importance.

Date of Request: _____

Provide a brief description of need. (300 words or less)

Other pertinent information you would like to share. (300 words or less)

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Please return application, including HIPPA release form, to:
North Valley Sparrow Foundation
Attn: Request for Funds
P.O. Box 934, Gridley CA 95948
or to nvsparrowfoundation@gmail.com
If you have questions or need assistance please contact 530-682-8861

North Valley Sparrow Foundation is a 501(c)(3) nonprofit. FEIN#82-1624777.

HIPPA RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability & Accountability Act, 45 C.F.R., Parts 160 & 164)

Privacy regulations require the North Valley Sparrow Foundation to obtain a release signed by patients (or their representative) so we may speak with family members, friends and other third parties regarding patient medical treatment and financial information.
Each person you wish to be considered a contact must be listed individually by name (including a spouse, child, parent or significant other).
Please print name, relationship to patient, and telephone number for each person to whom you are authorizing release of your private healthcare information and financial balances.
Please photocopy should you require more space.

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

This authorization covers the period from _____ to _____**OR** all past, present & future periods ☐

This medical/financial information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

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.

I understand that receipt of benefits from the North Valley Sparrow Foundation is not conditional upon whether I sign this release.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient, through no fault of the North Valley Sparrow Foundation, and may no longer be protected by Federal or State law.

Patient/Representative Signature Printed Name Date

Witness Signature Printed Name Date