seventeen22
FOUNDATION

Complete the following form & send via mail or email

Please note that if the application is not legible it will not be considered. *Absolutely no exceptions will be made for late or incomplete applications.*

Submit your application:

Mail: 8535 Plainview Road Krum, TX 76249

Email: theseventeen22@gmail.com

Patient Information:

Male ☐

First Name _____Last Name_____ Date of Birth ___/____/___ Age ____ Female ☐

Address_____ City_____ State___ Zip_____ County_____

Home Phone _____ Cell Phone _____ Email address _____

ARE YOU A UNITED STATES CITIZEN OR LEGAL RESIDENT?..... Yes ☐ No ☐

Have you received assistance from Seventeen22 Foundation before? Yes ☐ No ☐_____

If yes, please note the date you last received Family Aid: _____ Patients are only eligible to receive aid once per 12 months)

Insurance: Do you have the following (check all that apply):

Medical Insurance	Prescription Drug Plan	Medicare	Medicaid	NONE
☐	☐	☐	☐	☐

If patient is a minor, Legal Guardian to complete:

Name(s) of Legal Guardian _____ Relationship to the Patient _____

Daytime Phone _____ Cell Phone _____ Email _____

**** This section must be completed and signed by Provider****

This document is to verify that:

{Patient's Name}_____, **{DOB}**_____, remains under active care at our institution **{Name of Care Facility}**_____**{City, State}** _____ for the **diagnosis** of neurofibromatosis (type 1, type 2, or schwanamatosis)

Original Date of Diagnosis: _____

We hereby attest that this information is true and correct.

X_____ Date _____

1st Signature: M.D., D.O., P.A., N.P.

Print Name: _____

Title: _____

Phone: _____

Email: _____

X_____ Date _____

2nd Signature: N.P., Social Worker, Financial Advisor, Practice Manager

Print Name: _____

Title: _____

Phone: _____

Email: _____

**** Two separate signatures and contact information are REQUIRED from the Provider staff***

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Describe the circumstance supporting your request for financial assistance: *(Required)*

You may also attach additional pages if more space is needed.

Do you plan on using your assistance for any of the following (check all that apply):

Medical Bills ☐ Mortgage/Rent ☐ Utilities ☐ Vehicle/Transportation ☐ Other ☐

Patient Certification:

☐ I authorize Seventeen22 Foundation and its agents to access and review the information I have submitted herein, including any private or confidential health information. I understand that Seventeen22 Foundation intends to use this information in connection with their assessment of family aid and potential payment of family aid and will not disclose this information to third parties. This authorization expires one year from the date of submission, unless otherwise agreed.

By signing this document, I _____, hereby authorize the release of information in this application and related to my diagnosis to Seventeen22 Foundation for the purpose of seeking financial assistance. I affirm that all of the information provided in order to qualify for financial assistance is complete and accurate. I understand that I may be denied assistance if any of the above information is false, and that I may be required to repay any assistance that I have received based on false or incomplete information.

I understand and agree that:

(i) Seventeen22 Foundation in its sole discretion shall determine my eligibility, participation and termination in its Family Aid program;
(ii) Seventeen22 Foundation does not guarantee payment of patient aid;
(iii) Seventeen22 Foundation shall have no liability pursuant to my application, participation, continuation or termination in its Patient Aid program;
(iv) I authorize my Physician to release to Seventeen22 Foundation such medical information of mine as it may require to administer my application and participation in its Family Aid program;
(v) I authorize Seventeen22 Foundation to run a background check.

Signature of Patient or Legal Guardian _____Date_____

Printed Name _____

Photo Consent: (Optional)

**You may submit, with this application, your photograph (nonrefundable copy) for Seventeen22 Foundation. office use. Digital file is best.*

By signing this document, I _____, hereby consent to the use of my attached photographic image together with my name, age, city of residence, occupation, and type of NF for public use by Seventeen22 Foundation. I further release from liability and hold harmless Seventeen22 Foundation in the use of my image and information. Signature of Patient or Legal Guardian _____Date_____

Printed Name _____