PAY IT FORWARD WITH JACKIE INC.

Pay it Forward with Jackie Incorporated is a non-profit organization. Its mission is built on the hopes and dreams of a childhood cancer patient, a little girl, named Jackie, who inspires to "pay it forward". Its mission is to increase the number of donors on the National Bone Marrow Registry by hosting bone marrow drives in anticipation of finding the perfect match for those in need. In addition, Pay it Forward with Jackie Inc. is committed in providing relief to the under privileged by working with local food pantries, providing gift certificates and/or bill payments to qualified applicants with special consideration to families struggling with a childhood cancer diagnosis.

Financial assistance provided by Pay it Forward with Jackie is made possible because of generous donors. It is important that these funds are available for those in the greatest financial need.

APPLICATION FOR FINANCIAL ASSISTANCE

(Please note you must be over the age of 18 to apply)

Applicant' s Name:_____

SS Number:_____ DOB:_____ Gender:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Cell Phone:_____

E-Mail Address:_____

Number of People in Household: Adults_____ Children (ages 5 and up)_____Children

(under 5 years of age) _____

How did you hear about Pay it Forward with Jackie Inc.? _____

Do you have a child suffering from a childhood cancer diagnosis: **YES** or **NO** (please circle)

Without childhood cancer diagnoses skip to PART II

PART I (To be completed by Social Worker or Physician)

Hospital Name: _____

Hospital Address: _____

_____

Social Worker Name: _____

Social Worker Phone Number: _____

Patient's Name: _____

Patient's Diagnosis: _____

Date of Diagnosis: _____ Number of relapses: _____

Is child able to attend school? _____

Has there been a loss of employment as a result of diagnosis: Yes or No

Other agencies from which family has received help in the past year:

Social Worker/Physician Signature_____ Date _____

PART II

How many adults in the home are currently employed? _____

Combined weekly gross income (please include copy of paystub): _____

Amount of weekly income from all other sources:_____

Monthly rent/mortgage payment:_____

What is the result of your financial hardship?_____

Have you applied for SSI/SSD, Food Stamps, Cash Assistance, Unemployment?_____

If Yes, please circle appropriate program above and indicate if your application is pending, if you are currently receiving assistance or if you were denied:_____

If No, please check if you would like an application to apply for SSI/SSD, Food Stamps or Cash Assistance: _____

PART III

Assistance Requested

Check whether you are seeking a bill payment or gift card. You may only select **ONE**
(Please note the maximum amount per applicant is $250 based on fund availability)

Bill Payment _____(Copy of bill in applicants name must be included with this application, sorry but we cannot accept cell phone or cable bills.)
Gift Cards _____(please indicate your grocery or gas store choice or if you prefer Walmart/Target)
Amount Requested $_____
Other type of assistance requested: _____

Important Notification

Pay it Forward with Jackie Inc. does not discriminate against or deny aid because of race, religion, color, sex or political affiliation.

All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted and the availability of funds.

The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

Affirmation

I do hereby authorize hospitals, and State agencies to release to Pay it Forward with Jackie Inc., or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Signature:_____

Printed Name_____

Date:_____

For Office Use Only:

Approved By_____ Date _____

Amount Granted _____ Gift Card_____ Bill_____

Check # (if applicable) _____

Comments:

_____

_____

_____