



One of the objectives of the Addison Jo Blair Foundation is to assist families of children with cancer who are being treated at Norton Children's Hospital. Upon approval, the Foundation can provide needs assistance for gas, food, and other basic necessity items that directly benefits the child while minimizing some of the financial burden attributed to the child's illness.

"Helping Kids in Need... One Smile at a Time"

Application for Needs Assistance (Please Print)

Child's Name: _____

SSN: _____ DOB: _____ Gender: _____

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Email Address: _____

Annual Household Income: _____

Have you applied to the AJB Foundation before? _____ (Y/N) If YES, when? _____

Are you currently receiving any other financial/needs assistance via the government or other non-profit organizations?

_____ (Y/N)

If YES, please provide what type and specified amount _____

Needs: List in order from **greatest** to **least** the following needs: Gas; Food; Other Needs Items (toiletries, clothing etc.)

1. _____ 2. _____ 3. _____

****Please note: In order for your application to be reviewed, you must submit the following items:**

- Application for Needs Assistance
- Your child's medical information completed by medical professional at Norton Children's Hospital

Parent/Legal Guardian: _____ Date: _____

By signing this application, you are agreeing to allow your child's name and medical condition to be released to the Addison Jo Blair Foundation in order to grant possible financial assistance to your family.

Addison Jo Blair Foundation
167 Tattersaul Dr.
Elizabethtown, KY 42701
info@addisonjo-blair.org



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MEDICAL STATEMENT FOR ELIGIBILITY
(To be Completed by Medical Professional)

Child's Physician at Norton Children's Hospital: _____

Child's Diagnosis: _____

Date of Diagnosis: _____ Currently in ongoing treatment, maintenance therapy? (Y/N) _____

NCH Oncology Department Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email (Optional): _____

Please briefly describe the child's medical condition and anticipated length of treatment plan and/or protocol:
(Attach additional documentation if necessary)

Name and Title of Medical Professional at NCH
(Please Print)

Signature of Medical Professional at NCH

Parent/Legal Guardian: _____ **Date:** _____

By signing, you are agreeing to allow your child's name and medical condition to be released to the Addison Jo Blair Foundation in order to grant possible needs assistance to your child and family.

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