

## Application for Sy's Fund, Inc.

Sy's Fund is a fund for young adults ages 18-39 with cancer or serious ongoing medical issues stemming from cancer. We fund meaningful gifts and integrative therapies. We do not provide general financial assistance.

For questions or concerns regarding what types of things we fund or regarding information we need to process your application, please call Sy's Fund at 413-512-9177 or email us at [sysfund@gmail.com](mailto:sysfund@gmail.com)

Please send completed application to: *Sy's Fund, P.O.Box 356, Erving, MA 01344*

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of birth \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Email address (optional) \_\_\_\_\_

Name of Alternate Contact: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Sy's Fund would like your permission to share information in order to continue helping others. This could include things like sharing a quote from you on our website or Face Book page, or during fundraiser events for example. We do not share your information with other organizations.

**Sharing of information is voluntary, except as needed to determine eligibility and provide funding. If you prefer that we do not share your information it will in no way preclude you from receiving assistance from Sy's Fund**

I GIVE PERMISSION FOR SY'S FUND TO USE MY NAME & INFORMATION

I GIVE PERMISSION FOR SY'S FUND TO USE MY INFORMATION BUT WISH TO REMAIN ANONYMOUS.

I GIVE PERMISSION FOR SY'S FUND TO USE THE FOLLOWING INFORMATION ONLY:

\_\_\_\_\_  
 SHARE MY INFORMATION ONLY AS NEEDED TO PROCESS MY APPLICATION & PROVIDE FUNDING

\_\_\_\_\_  
**SIGNATURE OF APPLICANT**

\_\_\_\_\_  
**DATE**

**CHECK LIST OF ADDITIONAL DOCUMENTATION WE WILL NEED TO  
COMPLETE YOUR APPLICATION:**

- ✓ **Copy of drivers license or other photo ID (state photo ID, college/school photo ID) (can be sent through email, fax, or through mail with application)**
- ✓ **Medical release filled out by Oncologist/Oncology Social Worker or Registered Nurse Practitioner (we need original release: please mail with application)**
- ✓ **Release for integrative therapist if applicable**
- ✓ **Brief letter telling us a bit about yourself and what you would like us to fund**

**PLEASE EMAIL OR CALL SY'S FUND IF YOU HAVE ANY QUESTIONS  
REGARDING INFORMATION NEEDED:**

**EMAIL: [sysfund@gmail.com](mailto:sysfund@gmail.com)**

**PHONE: 413-512-9177**

**Website: [www.sysfund.org](http://www.sysfund.org)**

## SECTION I: MEDICAL RELEASE OF INFORMATION

To be completed by Physician, Oncology Social Worker or Nurse Practitioner

1. Your professional role (*check one – only professionals in roles listed here may complete this verification form*):

- Physician  Oncology Social Worker  
 Nurse Practitioner

2. Name of Patient: \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

3. Patient's diagnosis \_\_\_\_\_

4. Date of diagnosis \_\_\_\_\_

5. Current treatment \_\_\_\_\_

6. Any ongoing medical issues related to treatment or cancer \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. How long have you been treating this individual? \_\_\_\_\_

8. I currently see this individual:

- daily  weekly  monthly  other (specify) \_\_\_\_\_

Signature of professional: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PLEASE SEND ORIGINAL WITH APPLICATION TO SY'S FUND  
KEEP COPY FOR YOUR RECORDS

**SECTION II: MEDICAL RECORDS RELEASE (to be completed by patient)**

I authorize the professional identified in Section I to release the information requested on this form to Sy's Fund. I also authorize professional to speak to representative from Sy's Fund to verify information if needed.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print:**

Patient's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

PLEASE SEND ORIGINAL WITH APPLICATION TO SY'S FUND  
KEEP COPY FOR YOUR RECORDS

SY'S FUND  
P.O.Box 356  
Erving, MA 01344

PHONE: 413-512-9177

# INFORMATION & RELEASE FOR INTEGRATIVE THERAPIST

## To be completed by Professional providing treatment

1. Professional role/treatment you provide:

- Acupuncturist
- Massage Therapist
- Reflexologist
- Reiki Practitioner
- Cranial Sacral Practitioner
- Chinese Medicine Practitioner
- Other: \_\_\_\_\_

2. Name of Person being treated: \_\_\_\_\_

3. I currently see this individual:

daily  weekly  monthly  other (specify frequency) \_\_\_\_\_

4. Payment per treatment: \$ \_\_\_\_\_

Signature of professional: \_\_\_\_\_ Date: \_\_\_\_\_

### Please print:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please attach copy of license or certificate to release form.

PLEASE SEND ORIGINAL WITH APPLICATION TO SY'S FUND  
KEEP COPY FOR YOUR RECORDS

For more information contact: Sy's Fund at 413-512-9177

<http://www.sysfund.org> sysfund@gmail.com

**INTEGRATIVE THERAPY RELEASE (to be completed by patient)**

I authorize the professional identified in “Information and Release For Integrative Therapy” to release the information requested to Sy’s Fund.

Patient’s signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print:**

Patient’s name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

PLEASE SEND ORIGINAL TO SY’S FUND & KEEP COPY FOR YOUR RECORDS

SY’S FUND  
P.O.Box 356  
Erving, MA 01344

PHONE: 413-512-9177