

Application for Sy's Fund, Inc.

If you have any questions or concerns regarding the information we need to process your application, please call Sy's Fund at 413-512-9177:

Please send completed application to: Sy's Fund, 60 Freeman Dr. #5, Greenfield, MA. 01301

Name _____

Address _____

City _____ State _____ Zip _____

Date of birth _____

Phone () _____

Email address (optional) _____

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 the website, or during fundraiser events. 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 CALL SY'S FUND IF YOU HAVE ANY QUESTIONS REGARDING
INFORMATION NEEDED: 413-512-9177**

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: _____

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SY'S FUND
60 FREEMAN DRIVE #5
GREENFIELD MA 01301

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.

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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: _____

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