SEVENTEEN22
FOUNDATION

Complete the following form and send via email or mail. ***Please note that if the application is not legible, it will not be processed***.

**Submit your application:**

Mail: 8535 Plainview Road Krum, TX 76249

Email: info@seventeen22.org

**PATIENT INFORMATION**

First Name _____ Last Name _____ Date of Birth ___/___/___ Age ___ Gender ___

Address _____ City _____ State _____ Zip Code _____ County _____

Phone Number _____ Will you accept text messages? _____ Email Address _____

Are you a United States Citizen or Legal Resident? Yes No

Have you previously received funding from Seventeen22 Foundation? Yes No
If yes, please note the funding date: _____ (Patients are eligible to receive funding once per 12 month period.)

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

Medical Insurance Prescription Drug Plan Medicare Medicaid None

Demographic Information: Race _____ Annual Income _____ Occupation _____ Level of Education _____
*(answers to demographic information does not impact eligibility)*

**IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST COMPLETE**

Name: _____ Relationship to patient _____

Phone Number _____ Will you accept text messages? _____ Email Address _____

**THIS SECTION MUST BE COMPLETED BY THE 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 NF2-related schwanamatosis

Original Diagnosis Date _____

We hereby attest that this information is true and correct.

X _____ Date _____ X _____ Date _____
***1st Signature: MD, DO, PA, or NP*** ***2nd signature NP, Social Worker, Practice Manager***

Print Name _____ Print Name _____
Title _____ Title _____
Phone _____ Email _____ Phone _____ Email _____

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**DESCRIBE THE CIRCUMSTANCE SUPPORTING YOUR REQUEST FOR ASSISTANCE (REQUIRED)**
You may also attach additional pages if more space is needed.

Do you plan on using the assistance for any of the following? (check all that apply)
Medical Bills Mortgage/Rent Utilities Vehicle/Transportation Other (specify) _____

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 funding and potential awarding payment 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 _____ (name) hereby authorize the release of information in this application and related to my diagnosis to Seventeen22 Foundation for the purpose of seeking assistance. I affirm that all of the information provided in order to qualify for 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 programs;
(ii) Seventeen22 Foundation does not guarantee payment of funding
(iii) Seventeen22 Foundation shall have no liability pursuant to my application, participation, continuation or termination in its programs;
(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 programs;

Signature of Patient or Legal Guardian _____ Date _____

Printed Name _____