



# Angel Wings

In-kind support for those affected by cancer.

Please fill out this form completely and email to [wings@angelonmyshoulder.org](mailto:wings@angelonmyshoulder.org) or upload to our website [angelonmyshoulder.org](http://angelonmyshoulder.org)

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## ANGEL WINGS-EMBRACE Applications/Requests are considered for and granted on a one time basis to individuals and/or families.

**\*SPECIAL NOTE: Angel Wings was not created (nor are we able) to assist directly with financial needs (i.e. gas cards, payment of bills, insurance, rents, mortgages, automobile or house repairs, etc.). Angel On My Shoulder is unable to make any monetary payments to individuals.**

Please fill out the following questionnaire and Medical Provider Verification Form to have your request\* considered for Angel On My Shoulder's Angel Wings program. Information on all family members or other persons participating in the request must be included, as well as having the Medical Provider Verification Form completed.

Name of person with cancer: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female Email: \_\_\_\_\_

Parent/Guardian/Spouse/Other Responsible Person: \_\_\_\_\_

Indicate relationship to person with cancer: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

**Please list name, age and relationship of any other family members or other persons who will be participating in request:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Please describe your request\* in detail. Include actual or anticipated costs.** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If your request requires help with hotel, tickets or other activity, payment will be made directly to the vendor of those services. **Please get and keep receipts where applicable.** Contact us if you have any questions.

**Please indicate the date(s) for fulfillment of the request:**

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_, or between (date) \_\_\_\_\_ and (date) \_\_\_\_\_

**Please describe in detail the medical diagnosis of the person with cancer and how this request will benefit that person: \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIABILITY RELEASE**

The request person (or parent/legal guardian, and any other minor or adult participants, if any,) hereby release and agree to hold *Angel On My Shoulder* (Angel Wings program) harmless for, from and against any liability, damages, and claims of any kind, known and unknown, which may be connected with, result from, or arise out of the consideration, preparation, fulfillment or participation in the request, as currently requested or as altered in the future. This includes, but is not limited to, liability, damages and claims resulting from economic loss, physical injury, illness, or death. The request person and/or his or her agent or parent represents and warrants that he/she has not assigned any such claim or authorized any other person or entity to assert any claim on his/her behalf.

Parent(s)/legal guardian(s) of minor participants, and other adult participants, if any, further understand that involvement in the request may result in publicity, whether or not *Angel On My Shoulder* (Angel Wings program) actively takes steps to publicize the request. Additionally, in consideration of *Angel On My Shoulder* (Angel Wings program) considering the request, and if so determines, granting the request, the parent(s)/legal guardian(s) of minor participants, and other adult participants, if any, hereby release and agree to hold *Angel On My Shoulder* (Angel Wings program) harmless for, from and against any and all liability, damages and claims of any kind, known or unknown, which may be connected with, result from, or arise out of the use, distribution or disclosure of any photographs, films, videotapes, electronic recordings, art work, or other information regarding participants and the request, through any media whatsoever, including, but not limited to the Internet, electronic media and print publications.

**X** Request person's signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**X** Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**REQUIRED SIGNATURES**

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of *Angel On My Shoulder* (Angel Wings program) regarding the request.

I understand and recognize that the granting of any request and the participation of any person in the request is contingent upon approval by *Angel On My Shoulder* (Angel Wings program) as well as compliance with all conditions, qualifications and restrictions designated by *Angel On My Shoulder* (Angel Wings program).

I understand that the receipt of a request may impact the eligibility for public assistance and/or benefits.

I attest that the information provided by me is true and accurate to the best of my knowledge.

**X** Request person's signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**X** Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**X** Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**PLEASE REVIEW AND SIGN THE ABOVE FORMS. REQUESTS CANNOT BE REVIEWED WITHOUT SIGNATURES AND DOCUMENTATION. The Medical Provider Verification Form must be completed, signed and returned as well before we can consider your request.**

# Medical Provider Verification Form

Medical Provider, please complete this form for the person with cancer.

A request has been made for support from the Angel Wings program of Angel On My Shoulder. We require your verification of their cancer situation before we can complete their request.

Name of Person with Cancer		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate: MM/DD/YYYY	Date of Diagnosis: MM/DD/YYYY
Diagnosis					
Status of Disease:			Date of Last Chemotherapy: MM/DD/YY	Radiation Therapy:	
<input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> Remission; on therapy <input type="checkbox"/> Remission off therapy (completed date _____) <input type="checkbox"/> Relapse; on therapy <input type="checkbox"/> Other _____				<input type="checkbox"/> Yes <input type="checkbox"/> No Site of Radiation: _____ Last Treatment Date, MM/DD/YY: _____	
Name of Primary Doctor		Address		Phone	Email
Primary Treatment Facility		Address		Phone	Email
Medical Person Filling Out Form		Title		Phone	Email
		<input type="checkbox"/> Nurse <input type="checkbox"/> Social Worker <input type="checkbox"/> Case Worker			
Is there anything else you would like us to know about?					
<b>VERIFICATION OF CANCER SITUATION</b>					
In order to process this request, we need confirmation of this person's cancer diagnosis by his/her doctor, nurse, social worker or case worker.					
Name			Title		
Signature			Date		



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