Angel Wings

In-kind support for those affected by cancer.

Please fill out this form completely and email to embrace@angelonmyshoulder.org

ANGEL WINGS–EMBRACE Applications/Requests are considered for and granted on a one time basis to individuals and/or families who live in or have a connection to Wisconsin.

***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	Age	Birthdate: MM/DD/YYYY	Date of Diagnosis: MM/DD/YYYY
	❘ Male ❘ Female			
Diagnosis				

Status of Disease:	Date of Last Chemotherapy: MM/DD/YY	Radiation Therapy:
❘ Newly Diagnosed ❘ Remission; on therapy ❘ Remission off therapy (completed date _____) ❘ Relapse; on therapy ❘ Other_____		❘ Yes ❘ 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
	❘ Nurse ❘ Social Worker ❘ Case Worker		

Is there anything else you would like us to know about?

VERIFICATION OF CANCER SITUATION

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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