APPLICATION DIRECTIONS AND CHECKLIST

Follow Steps 1-6 to complete the ROBIN'S NEST application

Step 1: Read the OVERVIEW OF FINANCIAL ASSISTANCE on the first two pages.

Step 2: Fill out the ROBIN'S NEST Application completely and accurately.

Step 3: Provide the **Request for Medical Information Form** to your oncologist/physician to verify your diagnosis and return it to the address listed on the form.

Step 4: Read carefully the Release / Waiver of Liability section and sign the application

Mail your completed application and all required attachments to:

Rockin 4 Robin Inc.
15 North Sherry Lane
Bellevue, Kentucky 41073

NORTHERN KENTUCKY

APPLICATION FOR FINANCIAL ASSISTANCE

PERSONAL INFORMATION

Name: ____ Date of Birth: ___/__/___

Street Address: ____

City_____________________, Kentucky Zip _____________ County _______________

Phones: Home: ________________Work: _______________Cell: _________________

Best number to reach you: Home__ Work __ Cell __ Best time to call: _______

Additional Contact Person that we may discuss your application with, if we can't reach you:
Name:____
Phone: ____
Relationship: Spouse__ Parent__ Child__ Friend __ Other: ___________________

MEDICAL INFORMATION

What is your diagnosis? ____

Date of diagnosis: _________ Name of your treating oncologist/physician: _________________________

Are you currently undergoing treatment? ________ If no, when was your last treatment or surgery?
____

How did you hear about ROBIN'S NEST? ____

Name of person, if referred: ____

RELEASE/WAIVER OF LIABILITY

I understand that any award is made at the sole discretion of ROBIN'S NEST. I hereby release ROCKIN' 4 ROBIN, INC. D/B/A ROBIN'S NEST of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize the release of my name, address, and medical information or other documentation required by ROBIN'S NEST for the purpose of verifying this application.

Signature: ____ Date: _________________________

Printed Name: _____________________________________

ROBIN'S NEST is an assumed business name of Rockin' 4 Robin, Inc. Rockin' 4 Robin, Inc. is a 501(c)(3) nonprofit corporation.

NORTHERN KENTUCKY

REQUEST FOR MEDICAL INFORMATION

Instructions to patient: Sign your name below and deliver this form to your doctor.

I hereby consent for Dr. ______________________________ to provide the information requested below to ROBIN'S NEST. I understand that this information will be kept confidential and is important for the consideration of my application for financial assistance.

Signature: _____________________________________ Date: _________________

Parent or legal guardian if minor

Printed Name: _________________________________

Instructions for the Physician: Please complete to the extent possible, and mail to:

Rockin 4 Robin Inc.
15 North Sherry Lane
Bellevue, Kentucky 41073

Patient's Name: ____

Diagnosis and Date established: ____

Cancer Treatment Administered to Date: ____
____

Future Treatment Required: ____
____

Other Comments (other related expenses) ____
____

Physician's Signature: _________________________ Date: _______________

Physician's Name: ____________________________

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