CJR Memorial Foundation guidelines for referring social workers and other health care professionals

To allow us to process your requests in a timely manner, please mail or fax the following

If you fax the information, please do not mail a second copy

1. **A typed Cover Letter** on your office letterhead no longer than one page. Please state medical diagnoses, physical condition of the patient, family's financial situation, reasons for referral as well as what the request is for. In order to qualify for assistance, the child must be medically involved; i.e., currently or recently hospitalized at the time of your request, or receiving ongoing medical treatment at a medical facility or at home through specialized nursing care.

2. A typed or carefully hand printed CJR Memorial Foundation "**Information Sheet**." Please be sure to provide all requested information or we will be unable to process your request. Please type or carefully hand print the information sheet since it is often difficult to read faxed names, addresses, and account numbers with accuracy.

3. **Copies of all bills to be paid**. Please send us only the part of the bill that says "Return with payment."

4. **Mail to the following address:** care of CJR Memorial Foundation Financial Assistance: 1114 Dewberry Dr. Hawley, PA 18428

5. **Fax application to:** 570-955-3468

Mission Statement: The CJR Memorial Foundation is dedicated to financially assisting families in need so they do not have to leave their sick child's bedside; whether it be covering a rent or mortgage payment, electric or medical bill, or even groceries for the week. No parent should ever have to prioritize a payment or job before the care of their sick child.

If you have any questions, please contact the CJRMF at joseph@cjrmemorialfund.org

Thank you!

Personal Information Form

The data must be typed or carefully hand written and accompanied by a typed cover letter on hospital/agency letterhead. Confidential patient medical information, family history, and reasons for referral from a social worker or other healthcare professional must be provided.

Patients Name: _____ Birth Date: _____ Race: _____

Please provide name(s) of caregiver below: Parent(s) or Legal Guardian(s) etc…

_____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Employed Father/Mother/Caregiver: Yes____ No ____ Single Parent: Yes ____ No ____

Has caregiver left work or reduced hours because of child's illness: Yes ____ No ____

Are there other siblings living at home? If so, how many and what are their ages? _____

Annual Family Income (Estimate) $_____

Is patient's heath insurance covering treatment? _____

If yes, How much? _____

Referring Social Worker/ Case Manager Name: _____

Phone: _____ Fax: _____ Email: _____

Total amount of request $ _____ Request for: _____

_____

(Electric bill, Mortgage, Car Payment etc…)

Please include a copy bill(s) to be paid:

Check payable to: Name: _____

Receiver address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Phone Number (if applicable): _____

Check payable to: Name: _____

Receiver address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Phone Number (if applicable): _____

Check payable to: Name: _____

Receiver address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Phone Number (if applicable): _____

We cannot guarantee payment on multiple requests.
Be sure to list in order of highest priority!!