Wings of Love Application

Please mail or email completed application to:
14700 N. Frank Lloyd Wright Blvd.
STE# 157, PMB 197, Scottsdale AZ 85260
angelmamas@angelmamas.org
Questions: (480) 359-4MOM

PROGRAM CRITERIA

To apply for assistance, please complete the attached application and submit it to your medical professional, social worker or referral agency. ***The application must be submitted to angel mamas by a certified medical professional, social worker or your referral agency administrator on behalf of the family. No exceptions.*** You will be contacted if your application is accepted and is being considered for assistance.

angel mamas provides in-kind and financial assistance through the following categories. Applicants can receive assistance in these categories within one calendar year. If applicants are eligible for assistance, angel mamas will provide such assistance "only" by directly paying vendors.

Primary Categories	**Example**
Living/Home Expenses	groceries, gas, utility bills, repairs (critical needs only)
Health/Medical Expenses	one-time treatments, equipment not covered by insurance

Secondary Categories	**Example**
Childhood Development	counseling, tutoring, personal development
Childhood Extra-Curricular	camps, sports, etc.
Parental Development	coaching, counseling, financial advisement

Program timelines:

- The Wings of Love program begins each year on January 1 and ends on December 31.
- The angel mamas' Board of Directors meets once a month to review all applications. All decisions are announced during the last week of each month. (angel mamas can only make timeline exceptions for urgent circumstances.)

Children/patients must be citizens or lawful, permanent residents of the United States and currently receive treatment in Maricopa County, Arizona. Non-citizen residents applying for assistance must have and provide angel mamas with a photocopy (front and back) of their I-551 card (green card).

You will not be discriminated against or denied aid because of your race, religion, national origin, gender, disability or political affiliation. All applications will be reviewed by *angel mamas* on a case-by-case basis and final determination will be made based upon adherence to guidelines and the availability of funds and donated services. The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

PATIENT/CHILD FORM

Date _____

Patient's First/Last Name _____

Patient's Date of Birth _____ Age _____ Gender M / F

Patient resides with: ☐ Parents ☐ Guardians ☐ Other _____

Parents'/Guardians' Names _____

_____

Parents' Marital Status:

☐ Married ☐ Divorced ☐ Separated ☐ Unmarried

If not married, who has legal decision-making over the child?

_____

Home Address _____

_____

City _____ State _____ Zip _____

Primary Phone _____

Primary Email _____

Social Media URL(s): www.facebook.com/_____

other: _____

Please tell us about the child's illness/disease and treatment.

_____

_____

_____

_____

_____

_____

_____

Other information we should know to assist in our understanding of your situation and please tell us a little about the child's hobbies/interests.

_____

_____

_____

_____

_____

_____

Is patient covered by private insurance? ☐ Y ☐ N

If yes, what is the name of the plan? _____

Do you have a prescription drug plan? ☐ Y ☐ N

Do you have a secondary health insurance plan? ☐ Y ☐ N

If no, has or does the family have any plans or intentions to apply for one within the next 12 months? ☐ Y ☐ N

Is patient covered by a state or federally-funded insurance plan, such as Medicaid, Medicare, AHCCCS? ☐ Y ☐ N

If no, has or does the family have any plans or intentions to apply for one within the next 12 months? ☐ Y ☐ N

Household Salary (please check one): ☐ Under $20K ☐ $20-40K ☐ $40-60K ☐ $60-80K ☐ $80-100K ☐ Over $100K

Other income (per month): Social Security Income $_____

Child Support $_____ Other $_____

Has patient applied for assistance from another organization within the last 12 months? ☐ Y ☐ N

If yes, did patient receive assistance? ☐ Y ☐ N ☐ Not yet

If yes, what organization? _____ Amount? _____

If "not yet" when is response deadline? _____

Have either parents or guardians ever been charged with a crime (whether convicted or not)? ☐ Y ☐ N

If yes, please explain _____

_____

Have you had any past or present involvement with Child Protective Services? ☐ Y ☐ N

If yes, please explain _____

_____

Have either parents or guardians used and/or abused illegal drugs or illegally obtained prescription medication? ☐ Y ☐ N

If yes, please explain _____

_____

The undersigned, individually and as the parent/guardian of the child/patient, hereby acknowledges and agrees that the information submitted herein is accurate, true and complete to the best of his/her knowledge. I further acknowledge and agree that by the execution of this application I am granting angel mamas and its Directors permission to contact any and all medical provider(s) to confirm the foregoing information. I further acknowledge and agree that any and all sums received from angel mamas by the undersigned shall be used solely for the purposes specified in this application. I further agree to indemnify and defend angel mamas and its Directors against any costs, claims and expenses, including reasonable attorneys' fees, arising out of the breach of this agreement.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

MEDICAL FORM (to be completed and verified by medical professional or referral agency)

Hospital/Organization _____

Address _____

_____

City _____ State _____ Zip _____

Physician's Name _____

Phone _____

Social Worker/Administrator _____

Phone _____

Email _____

Patient's present diagnosis _____

_____

_____

Date of diagnosis _____

How often does the patient receive treatment and what is the form of treatment? _____

_____

_____

_____

Are there other treatment facilities involved in patient's care? ☐ Y ☐ N

If yes, facility name(s): _____

_____

What type of assistance is the patient/family requesting (check all that apply)?

- ☐ Living/Home Expenses
- ☐ Health/Medical Expenses
- ☐ Childhood Development
- ☐ Childhood Extra-Curricular
- ☐ Parental Development
- ☐ Other

Please explain the assistance requested:

_____

_____

_____

_____

Do you approve of the patient/family's request? ☐ Y ☐ N ☐ Partially

Please explain: _____

_____

_____

_____

Please provide any additional information:

_____

_____

_____

_____

I hereby acknowledge and agree that the above medical information I have submitted is accurate, true and complete to the best of my knowledge.

Printed Name _____ Title _____

Signature _____ Date _____

Please forward applications to angel mamas, 14700 N. Frank Lloyd Wright Blvd., #157 PMB 197, Scottsdale AZ 85260 or via email to shiran@angelmamas.org. Please call 480-359-4MOM with questions or concerns.

MEDICAL RELEASE AND AUTHORIZATION:

Please read and sign below. Make sure to have this medical release signed and dated by a witness (an adult, 18 years old or older, other than yourself).

I understand and grant my permission to all my doctors, social workers, clinics and hospitals to release all healthcare and billing information relating to my treatment and care to angel mamas Inc. (angel mamas). I also grant my permission to discuss the above information with any designated representative of angel mamas.

angel mamas agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission. I specifically authorize the release of all my healthcare and billing information in your organization's possession. The purpose of my request is to assist angel mamas in determining my eligibility for financial assistance. This Release and Authorization shall expire twelve (12) months from its execution if not revoked prior thereto. angel mamas will not disseminate or release these medical records to any outside source without first obtaining prior express consent. I understand and agree that fulfillment of assistance may result in publicity whether or not angel mamas actively takes steps to publicize its service. I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by angel mamas. I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of service being requested and offered. I understand and agree that no promises or assurances whatsoever have been made to me by any representative of angel mamas regarding the assistance I am requesting.

Patient's Name _____ Parent/Guardian Name _____

Signature of Parent/Guardian _____ Date _____

PUBLICITY NOTICE-RELEASE:

Assistance is made possible through generous donations. Therefore, angel mamas may hold events and fundraisers throughout the year to raise money to provide products and services to support children and families fighting life-threatening illnesses and diseases. People continue to support us because they want to see their money find its way to the people who need it the most. We need your help to put a face and a name to that cause. To accomplish this, we will use your family photos, your first names and your submitted conditions. If your application is approved, angel mamas may also use a brief description of how the assistance that you received has helped you. This will facilitate communication with our donors and help in attracting more contributors. Please acknowledge this notice-release by signing below.

angel mamas may arrange for photos to be taken. I hereby acknowledge that angel mamas may use the first names and photos of my immediate family members, as well as submitted medical background and story in PR and marketing materials which will include, but not be limited to, its newsletters, website, mailings and general information brochures.

Patient's Name _____ Parent/Guardian Name _____

Signature of Parent/Guardian _____ Date _____