JUSTIN KUKOWSKI
FOUNDATION

Living Well With Cancer Scholarship Application

Thank you for taking time to apply for a Justin Kukowski Foundation Scholarship. To ensure we have all the information needed and in the order needed for evaluation, please complete this application in full and follow the instructions along the way.

Once completed, please submit all your information to the Justin Kukowski Foundation:

By Mail: Justin Kukowski Foundation
ATTN: Scholarship Committee
112138 Haering Ct. W
Chaska, MN 55318

---

1. Applicant's Full Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

2. Applicant's Complete Address:

_____
STREET ADDRESS

_____
STREET ADDRESS (SECOND LINE)

_____
CITY STATE/PROVINCE POSTAL CODE/ZIP CODE

_____
COUNTRY

_____
PHONE E-MAIL ADDRESS

Is it okay to leave a message on your phone? Yes ❑ No ❑

Inform me regarding my application via: Email ❑ Mail ❑

3. Responsible Party (If different than above):

_____
LAST NAME FIRST NAME MIDDLE INITIAL

_____
STREET ADDRESS

_____
STREET ADDRESS (SECOND LINE)

_____
CITY STATE/PROVINCE POSTAL CODE/ZIP CODE

_____
COUNTRY

_____
PHONE E-MAIL ADDRESS

4. Please list the people in your household:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Financial Information:

Total Monthly Household Income (after taxes): _____

Estimated Household Assets (do not include retirement accounts):
Checking:_____ Savings CD:_____ Stocks:_____
Savings Bonds:_____ Money Market_____ Other:_____

Total Estimated Household Assets: _____

6. Please provide any additional comments regarding your situation that might be helpful when reviewing your application. (You may also include them as an attachment, limited to one page.)

_____
_____
_____
_____

7. I have submitted a photograph to be used if I am selected as a scholarship winner: Yes / No
[Please note: We welcome digital photos, email them to photos@justinkukowskifoundation.org]

8. I have signed and submitted the attached "Assignment of Rights & Consent to Publish Scholarship Information": Yes / No

ASSIGNMENT OF RIGHTS & CONSENT TO PUBLISH SCHOLARSHIP INFORMATION

KNOW ALL PERSONS BY THESE PRESENTS:

THAT I, _____, do hereby give Justin Kukowski Foundation 501C3 nonprofit organization, full rights to publish my name, where I live (city, state, and country only; actual street addresses and phone numbers will not be disclosed), my pertinent family information, treatment I am receiving, photographs that I have provided.

I understand that by execution of this agreement, I am relinquishing my rights to any future compensation for reproduction, publication or use of the above information by Justin Kukowski Foundation, in its print or electronic correspondence, catalog, or on its website.

I hereby specifically waive my right to review or approve THE MODIFICATION of the above Information. (Modifications may be made to accommodate size or content restrictions. Modifications will not be made to "distort" or "falsify" any information provided.)

I understand that this Agreement in no way obligates The Justin Kukowski Foundation to publish or use the above-described information.

EXECUTED this date of _____.

By: _____
(Print Name)

_____
(Signature)

Patient Release Form

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Justin Kukowski Foundation. I hereby give my permission that this application and all information provided can be sent to Justin Kukowski Foundation and discussed with my health care professional. All information reviewed is confidential.

Patient Signature: _____Date:_____

Print Name:_____

Please take some time to answer the questions below:

I would like to be on Justin Kukowski Foundation's mailing list? Yes ❑ No ❑

How did you hear about Justin Kukowski Foundation?

❑Social Worker Name:_____
❑Nurse Name:_____
❑Oncologist
❑Patient Financial Counselor
❑Patient Navigator
❑Friend Name:_____
❑Internet
❑Brochure
❑Other:_____

Medical Information Form

***THIS FORM IS TO BE FILLED OUT BY SOCIAL WORKER OF HEALTH CARE PROFESSIONAL**

Patient Information

First Name:_____Last Name:_____

Date of Birth:_____ Gender:_____ Veteran: yes ❑ no ❑
Racial/Ethnic Identity:_____Marital Status:_____
Diagnosis_____ Stage:_____ Date of Diagnosis_____

Current Treatment (Check all that apply)

❑Chemotherapy Date of Last Treatment:_____

❑Radiation Date of Last Treatment:_____

❑Bone Marrow Transplant Date of the Last Treatment:_____

❑Surgery Date of Last Surgery:_____

❑Palliative Care Date Entered:_____

❑Hospice Date Entered:_____

TO BE SIGNED ONLY BY TREATING ONCOLOGIST, REGISTERED ONCOLOGY NURSE, OR LICENSED MEDICAL SOCIAL WORKER
I attest that this patient has cancer and is currently being treated as stated above

X_____

Clinic Information

Clinic:_____ Oncologist:_____
Address:_____Phone:_____
City:_____State:_____Zip:_____

Social Worker/Health Care Professional Information

Name and Credentials:_____ Phone:_____
Clinic/Organization:_____ Fax:_____
Address:_____ City:_____
State:_____ Zip:_____ Email:_____