## ELIGIBILITY

# Dancers Care Foundation Phoenix Application

Applicant must be age 25 or under when diagnosed with cancer and currently undergoing active treatment for cancer. Additionally, applicant must have been a professional dancer or dance student dancing at least five hours per week at the time of diagnosis. An applicant is eligible until he/she has been off active treatment for one year.

It is our goal to offer cancer patients support through their treatment regiment. Due to the large number of applications that we receive we cannot accept all applicants.

## APPLICATION

In order to be considered for participation in our program the applicant/applicant's family must submit a completed application. All forms must be signed or, if a child, then BOTH parents/guardians must sign. The medical assessment MUST be filled out and signed by the physician and dance teacher/studio director or company director.

## PATIENT APPLICATION

### Part I (To be completed by an adult patient or by parent/guardian if child is the recipient)

Patient's Name: ____________________________________________________

Birthdate (Month/Day/Year) ______________________

Age _____

Sex ___M ___F

Street Address ____________________________________________________

City _________________________________ State _______ Zip _______________

Phone: ___________________ Email: ____________________________________

Employer (if applicable) Name, Address & Phone:

___________________________________________________________________________

___________________________________________________________________________

If patient is under 21:

Mother's Name: ______________________________________________

Street Address ____________________________________________________

City ______________________________ State ______ Zip ______________

Phone: _________________ Email: ______________________

Father's Name: ___________________________________________________

Street Address ____________________________________________________

City ______________________________ State ______ Zip ______________

Phone: __________________ Email: ___________________________________

Legal Guardians (if other than parents) __________________________________

Street Address ____________________________________________________

City ______________________________ State ______ Zip ______________

Phone: _________________ Email: ___________________________________

Note: If a child is under the custody of one parent or guardian, please attach a copy of the child custody order or both parents or guardians must sign all documents.

____________________________________________________________________

Mother's or Legal Guardian's Signature Date

____________________________________________________________________

Father's or Legal Guardian's Signature Date

PART II - Medical Assessment: (To be completed by physicians)

Please also attach diagnosis report and sign letter from the doctor on Hospital letterhead.

Hospital where patient is treated_______________________________________

Street Address _____________________________________________________

City ______________________________State _______ Zip ________________

Physician __________________________________________________

Phone ________________________________

Name of physician completing assessment (Please Print)

________________________________________________________

Hospital (if different from above) _____________________________________

City ____________________ St ________ Zip ____________

Phone/Fax _______________________________/___________________________

Diagnosis _____________________________________________________________

Date of Dx ____________ Is this condition considered ___ life threatening ___ life long, ___ short life expectancy?

Is the patient undergoing continued treatment? ___ Yes ____ No

If so, how often? _______________________________________________________

What treatment is the patient undergoing?

______________________________________________________________________

If treatment has ended, when was the last date of treatment?

________________________________

How often is the patient seen by the doctor?

_____________________________________________

Date of Last Visit: ______________________

Physician's Signature _________________________________ Date _____________

Comments:

## PART III – Dance History

Name of Dance Studio, School, Company or Job

_______________________________________________________________________

Name of Director _____________________________________________

Street Address _________________________________________________________

City __________________________ St ________ Zip _____________

Phone/Fax ________________________/ ____________________________________

Number of Hours Dancing per week before diagnosis: ________

Dance classes taken before diagnosis (e.g., ballet, modern, jazz, tap) and number of hours/week

_______________________________________________________________________

Participated in Competitions _____ Yes ______ No How Many Years? ___

If Professional Dancer, please answer the following:

What Performances or Shows have you danced in? ____________________________

__________________________________________________________________________

__________________________________________________________________________

Comments:

Studio/Company Director Signature _______________________________Date _______

## PART V – Cancer Organizations Assistance

If the patient ever received any financial assistance from a cancer organization or other grant giving organization, please give details including dates and amounts.

## PART VI – Phoenix Favorites

Favorite Color:

Favorite Animal:

Favorite: Store:

Favorite Restaurant:

Favorite Dancer or Dance Group:

Other Favorites you want to put down: