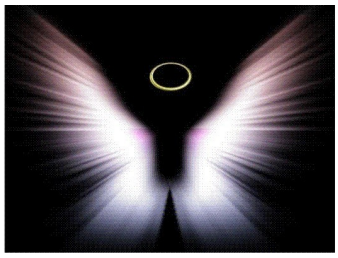
SILENT  ANGELS

PROGRAM INFORMATION

The Silent Angels provided free Breast Massages to low-income patients undergoing Breast Cancer treatment. Silent Angels is a program of G[ALEX] Foundation and is funded by generous donors.

The free Breast Massages will be provided by Licensed Massage Therapists who have training and experience in Breast Massage. All treatments will take place at Therapie.

APPLICATION REQUIREMENTS

Participants who benefit from Silent Angels must be:

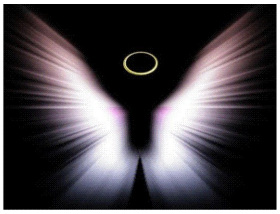
- 18+ years old
- Undergoing Breast Cancer treatment
- Must meet income-eligibility, based on Federal Poverty Guidelines
- Complete an application and provide proof of income, Dr's referral/prescription, and a Medical Record Release

Mail or fax completed application and required documents to:

G[ALEX] Foundation
7121 W. Craig Road #113-185
Las Vegas, NV 89129
(702) 205-3729 phone
(702) 804-6369 fax
galexfoundation.org

GALEX FOUNDATION

Enriching lives through tennis and wellness programs

SILENT  ANGELS

Program Application

Applicant:

Name_____ **DOB**_____

Address_____ **SS#**_____

Phone_____ **Email**_____

Household (Applies to everyone Applicant lives with)**:**

Persons living in the home_____: □ Spouse/Partner □ Children #_____ □ Others #_____

Applicant Employer_____ □ Full-time □ Part-time □ Self Employed

Applicant Income/Per_____ (W2, 1099, or 2 recent/consecutive check stubs required)

Applicant Health Insurance_____ Co-pay/Co-Insurance_____

Spouse Employer_____ □ Full-time □ Part-time □ Self Employed

Spouse Income/Per_____ (W2, 1099, or 2 recent/consecutive check stubs required)

Spouse Health Insurance_____ Co-pay/Co-Insurance_____

Other Employer_____ □ Full-time □ Part-time □ Self Employed

Other Income/Per_____ (W2, 1099, or 2 recent/consecutive check stubs required)

Other Health Insurance_____ Co-pay/Co-Insurance_____

Treatment

Diagnosis_____ Prognosis_____

Treatment Status_____

Oncologist/Clinic_____

Address_____

Phone_____ Fax_____

I authorize Therapie/Massage Therapist and Executive Director of G[Alex] Foundation to obtain my pertinent medical records from the above physician/clinic for Continuity of Care. Signature_____ Date_____

Requirements: 1) Proof of income 2) Dr's Referral/Prescription 3) Medical Record Release
Incomplete applications will not be processed.

Waiver

I acknowledge that Massages services provided by the Silent Angels program is paid for by donations and is free to me, and that participation in this program is wholly voluntary. As such, I hereby agree to hold harmless, release and forever discharge G[Alex] Foundation, their directors, officers, faculty, staff or employees, volunteers, and agents, from any and all actions, causes of actions, including negligence, claims and demands for damages, loss or injury, resulting from or arising out of my participation in this program.

I also acknowledge understanding that the Massage Therapist who provides treatment to me is solely responsible for their training, professionalism, and liability risks.

Signature_____ Date_____

Send completed application and required documents to:
G[Alex] Foundation
7121 W. Craig Road Suite 113-185
Las Vegas, NV 89129
(702) 205-3729 phone
(702) 804-6369 fax

OFFICE USE ONLY: Do not write in this area.
Complete Application: □ Yes □ No
Total Household Annual Income: $_____
Income Eligibility: □ Yes □ No
Approved: □ Yes □ No
If Yes: $_____**/# TXs**_____
Approved by:_____**Date:**_____