



**Complete – Print (2 copies) - Sign
Mail or FAX 1.800.251.6483**

Application for Client Status

Date: _____

Patient First Name: _____ Last Name _____ Sex: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____ Phone (home): _____ (cell): _____

Email: _____ Birthday _____

Marital Status: _____ Spouse name: _____ # Dependents: _____

Employer (current or previous): _____ Phone: _____

Employer address: _____

Current diagnosis: _____ Date diagnosed: _____

Physician or Clinic treating:

Your current prognosis:

IMPORTANT: How much **out-of-pocket expenses** (over and above insurance benefits) have you incurred to this point: **TOTAL AMOUNT** _____

Patient Signature: _____ Date: _____

I the undersigned have provided the above information to T.L.C. and do testify that it is true and current. I release all information to T.L.C. or its representatives. I also agree to a background check to help combat fraud in this program:

Release for minor under 18:

Print Minors Name: _____

Print Parent or guardian name: _____

Signature of Parent or Guardian: _____ Date: _____

Information provided to T.L.C. is the confidential property of the organization. The information will not be sold or disseminated to any other party, entity, or organization. Any client information provided to T.L.C. through the website will be approved in writing by the client. Any fraudulent or misleading information will result in immediate cancellation of the agreement and possible prosecution.



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Medical Information Release

Date: _____
 Patient First Name: _____ Last Name _____ Sex: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN#: _____ Phone (home): _____ (cell): _____
 Email: _____ Birthday _____

TO: _____
 Physician or Clinic name here

You are authorized to give The Lighthouse Community, or its representatives, any information you may have regarding my condition while under your treatment.

- Beginning date of treatment
- Current diagnoses
- Current prognoses
- Short summary of future treatments required to treat this condition
- Any additional information that would be helpful to process the patient request for financial assistance through The Lighthouse Community.

Patient Signature: _____ Date: _____

I understand I am releasing these records so that The Lighthouse Community can administer and process the disbursement of funds according to the IRS standards for a non-profit corporation. I understand these records will be treated confidentially in accordance with the laws of the State of Washington (RCW 51.28.070). This authorization can be withdrawn by me at any time.

Release for minor under 18:

Print Minors Name: _____

Print Parent or guardian name: _____

Signature of Parent or Guardian: _____ Date: _____

Dear Health Care Provider - The information requested above should be on Clinic/Physician letterhead, addressed to The Lighthouse Community, and signed and dated by the Physician.

Please sign and MAIL to:
 The Lighthouse Community
 11108 Woodland Ave
 Puyallup, WA 98373

OR

Please sign and FAX to:
 1.800.251.6483



**Complete – Print 2 (copies) - Sign
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Name/Photo/Video Release

Date: _____

Patient First Name: _____ Last Name _____ Sex: ____ Age: ____

Address: _____ City: _____ State: ____ Zip: _____

SSN#: _____ Phone (home): _____ (cell): _____

Email: _____ Birthday _____

I hereby grant permission to T.L.C., Puyallup, Washington, to use my name, photograph, video, or sound byte(s) on its website, www.thelighthousecommunity.org, or in other publications or presentations without further consideration, and I acknowledge T.L.C.'s right to crop, edit any image or audio/sound byte at their discretion. I understand that T.L.C. may choose to not use these images at this time, but may do so at its discretion at a later date.

Print Name: _____

Signature: _____ Date: _____

Release for minor under 18:

Print Minors Name: _____

Print Parent or guardian name: _____

Signature of Parent or Guardian: _____ Date: _____

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