



## YOU HAVE BEEN NOMINATED FOR A MIP KIT!

Fighting cancer not only takes a lot of physical energy, it takes a lot of mental energy. It isn't always easy being positive day after day when you are facing so many challenges. A MIP Kit is filled with tools that help keep your mind sharp but are fun too! MIP Kit items can help you "turn off" the worry as well as encourage you to see how truly strong you are.

The MIP Foundation's mission is to encourage mental health support and social services for Teenage Oncology Patients while increasing awareness about the effects of Pediatric Cancer.

Cancer treatments alter the direction of your life. It is incredibly important to develop the skills to understand and make peace with these changes and move forward to be able to leave their diagnosis behind them. Learn more about us at [www.themipfoundation.org](http://www.themipfoundation.org).

The MIP Foundation funds certain activities, tools, and support mechanisms for teens and young adults with cancer to help them with the mental stress brought on by their illness and treatment. The MIP Foundation is not a health care provider and does not provide medical treatment or advice.

### ELIGIBILITY

Any adolescent or young adult between the ages of 13-25 that is a patient currently undergoing treatment or suffering from the late effects of cancer treatment. It will be at the discretion and approval of your health care providers as to what activities a patient is able to participate in.

### POLICIES

The MIP Foundation does **NOT** approve applications on a first-come, first served basis. All requests will be reviewed individually and considered for funding. We seek and value the opinions of an applicant's social worker, nurse practitioner, and oncologist in determining a candidate's eligibility. Awards are based on available resources and funding.

Only requests submitted through a social worker or child life specialist with a signed Participation Agreement and Media Release/Consent will be considered for funding. Applications are not considered complete until all information is submitted. Submission of these forms does not guarantee acceptance by The MIP Foundation.

### PLEASE COMPLETE THE FOLLOWING AND HAVE YOUR NOMINATOR RETURN TO US:

- Signed Participation Agreement from Parent or Guardian (Page 2)
- Signed Media Release/Consent from Parent or Guardian (Page 3)
- Completed basic patient and parent contact information (Page 4)
- Completed MIP package information sheets so that we can personalize the kit (Page 5-10)

The nominator will scan and return the completed forms to The MIP Foundation.

A MIP Representative will contact the nominator to customize the experience and coordinate delivery.

## PARTICIPATION AGREEMENT

\_\_\_\_\_, the child's \_\_\_\_\_ is requesting  
 (Parent/Guardian's Name) (Relationship)

to receive services from The MIP Foundation for \_\_\_\_\_.  
 (Patient's Name)

By signing below, you are confirming with your signature that you have read and understand our eligibility, and you are confirming that your child meets these requirements. You are giving permission for medical professionals/social workers/child life specialists to confirm medical information about your teen, in addition to discussing ideas for how The MIP Foundation will provide resources/activities to your teen.

In exchange for the MIP Foundation's consideration of your child's application and the resources that it will provide if they are selected, I agree to release the MIP Foundation, its employees, volunteers, and trustees from and against any and all liability, damages, and claims that arise, regardless of the reason they occur or the grounds on which they are based, in connection with the MIP Foundation's consideration of my child's application and any resources that it provides, from this time forward. I intend this release to be binding on their heirs, assigns, and anyone else who may now or in the future bring a cause of action or make a claim on their behalf.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

## MEDIA RELEASE/CONSENT

### **MEDIA RELEASE/CONSENT:** *(Required)*

The MIP Foundation donates LOVE to see how we help. When we share our stories, it increases donor awareness and encourages contributions when they see how their donations are making an impact. Oftentimes, this is done through our social media presence, online website (TheMIPfoundation.org), or digital and print publications including, but not limited to, donor newsletters, posters, pamphlets, and advertisements. When these moments arise, it is important that The MIP Foundation know how to proceed with the individual identified below.

- YES.** I grant The MIP Foundation full permission to release, disseminate, reproduce, publish, or use any resulting words, recordings, and/or images of (Name) \_\_\_\_\_ or any other identifying information, including the identified individual's full name, images or likeness, diagnosis, or treatment center, in any manner it sees fit, including in any promotional, informational, or educational materials online, on film or photographs, or in print, including digital print media, for the purpose of promoting the MIP Foundation, its programs, initiatives, and fundraising efforts. By checking this box, I waive the right to inspect any product containing the identified individual's name and/or photo prior to publishing. I also waive the right to hold The MIP Foundation responsible for the usage of the identified individual's photo, name, or likeness. I understand that there will be no compensation associated with the use of the identified individual's photo and/or name.
- NO.** I do not wish to have (Name) \_\_\_\_\_'s photo or name used for any promotional materials by The MIP Foundation for any purpose.

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*Signature of the Identified Individual*

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*Date*

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*Name of Parent/Guardian (if under 18)*

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*Parent/Guardian Signature (if under 18)*

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*Date*

## PATIENT AND PARENT/GUARDIAN INFO

To be used to coordinate services provided by The MIP Foundation. This information will **NOT** be shared with any other organizations unless explicit/additional permission is granted by the parent.

**Patient Name:**

**Gender:**

**Birthdate/Age:**

**Date of Diagnosis:**

**Ethnicity:**

- American Indian or Alaska Native  
 Asian  Black or African American  
 Hispanic or Latino  
 Native Hawaiian or Other Pacific Islander  
 White

**Diagnosis, Challenges Due to Diagnosis/Treatment:**

**Is your child's treatment mostly in or outpatient? Do they have weekly clinic visits?**

**Treating Oncologist and Treating Hospital:**

**Nominator Name & Position:**

**Parent/Guardian (1):** *Name and Relationship*

**Parent/Guardian (2):** *Name and Relationship*

**Home Address**

Street

City

State

Zip

**Parent/Guardian Email Address:**  *Check here to receive MIP Foundation emails, newsletter and event info*

**Parent/Guardian Home Phone:**

 -    -    

**Parent/Guardian Cell Phone:**

   -    -    

**Preferred Method of Contact (check one):**

- Cell-Call  Cell-Text  Home-Call  Email

## NOMINATOR QUESTIONNAIRE

MIP Kits are a collection of carefully curated mental health items that take into consideration the patient's specific needs and cancer diagnosis. The information you will be providing in the questions below helps us to personalize the contents of the MIP Kit to more effectively meet the patient's needs, which increases the likelihood of the Kit's success.

**What coping skills do you see your patient using that they could expand upon? Are there any coping skills you feel your patient would benefit from?**

**Have there been any recent life changes aside from cancer diagnosis that we should be aware of? (Ex. Family changes, losses, a new pet, a change in peer group, etc.)**

**What physical or functional limitations does the AYA have that we can accommodate for when selecting materials for the MIP kit? (Ex. gross or fine motor limitations, vision loss, sensory sensitivity, reading difficulty, etc.)**

**Is there anything you feel would be helpful for us to know/consider when making your patient's MIP Kit?**

## PATIENT QUESTIONNAIRE

### **The Most Important Person in your treatment plan is YOU!**

A MIP kit will be customized just for you. Please provide as much information as possible – the more information you provide, the more tailored your kit will be to fit YOU!

**Do you have any restrictions/allergies/special accommodations needed?**

**What are your hobbies? Are there new hobbies you would like to try (drawing, coloring, models, puzzle books, card tricks, painting, jewelry making, sewing, etc.)?**

**How do you feel about art? Did you know, art can be wonderful tool to help with stress? It isn't about making a masterpiece. Rather, art is about relaxing and having fun! Is there a style of art you would like to try? For example: sketching, watercolors, adult coloring books, paint by number, etc.**

**Do you have any favorite colors? Or colors that make you happy, help you relax or cheer you up?**

## PATIENT QUESTIONNAIRE

**What is your shirt size?**

**Tell us how you feel about reading. Does reading help you to relax? Are there any books you would like to read?**

**Favorite food place? (Chick-Fil-a, Chipotle, Wawa, 5 Guys, etc)**

**What helps you to relax and lower your stress?**

## PATIENT QUESTIONNAIRE

**So, how do you turn pain into power? Hearing the words “you have cancer” can be like a bomb exploding right next to you! You may have countless thoughts and feelings happening all at once. Here is an important fact to know: There are no right or wrong feelings to have.**

**Cancer is a huge interruption into your life! Now is the time to consider learning new ways to manage and cope with your diagnosis. More importantly, you need to find the coping tools that fit your personality and interests.**

**Pick at least 1–2 of the following tools that most interest you.**

***Train your mind to focus and redirect your thoughts to where YOU want them to go.***

- I would like to learn to reduce stress, decrease anxiety, and feel more balanced. The fancy term for this is mindfulness or meditation.

***Decrease stress, improve sleep, cultivate calm, and control pain by mastering how you breathe.***

- I would like to learn simple breathing and relaxation methods.

***Express yourself while increasing awareness through writing. Writing can be just for you or can be shared.***

- I would like to keep a journal to help explore my emotions during treatment, release tension, and reduce stress.

***Discover more about who you are and what makes you tick.***

- I would like opportunities for self-reflection and personal discovery.

***Experience the benefits of deep, passive stretching through restorative yoga which allows you to practice when your energy is low and help your body to build strength. Also, cultivate body awareness, deepen self-awareness and quiet your mind.***

- I would like to learn restorative yoga for physical and mental balance and to prevent stress and anxiety.

***When feeling stressed out or tired, scents such as lavender, orange, peppermint or ginger can help to lift your mood, decrease stress, and anxiety.***

- I am interested in aromatherapy to feel calmer and more energized.
- Are there any scents you don't like? \_\_\_\_\_



## PATIENT QUESTIONNAIRE

**Pick one app listed below you would like to try.**

- The **Relax Melodies: Sleep Sounds App** allows you to combine and create your own sounds and melodies. It can help you fall asleep or you can create your own mix for relaxing and calming activities.
- The **Headspace App** is filled with hundreds of themed sessions on everything from stress and sleep to focus and anxiety, bite-sized guided meditations for busy schedules, SOS exercises in case of sudden meltdowns.
- The **Mood Kit App** provides tools for managing depressed mood, anxiety and stress that are built upon principles of Cognitive Behavioral Therapy (CBT).
- The **Mind Shift App** is designed to help manage and decrease stress and anxiety. Using CBT tools, you can challenge negativity, learn more about anxiety, develop more effective ways of thinking, be mindful, and relax.
- The **Calm App** helps to lower stress and anxiety and encourage a more restful sleep with guided meditations, Sleep Stories, breathing programs, masterclasses, and relaxing music.

**Do you have a digital device? (If so, what type? Phone, iPad, Laptop)**

**Do you have noise canceling headphones?**  yes  no

**If not, is this something you feel would help you relax?**  yes  no

**Do you prefer over-the-ear headphones**  **or in-ear buds**  ?

## PATIENT QUESTIONNAIRE

**Are there any digital subscriptions that you don't have and would like to try? For example: Netflix, Spotify, Apple Music, Hulu, Disney+, etc.**

**What is your "Go-To" thing that makes you feel better on a bad day?**

**We know you are unique and special! What else do you want us to know?**

**Is there something else that will help you manage your treatment?**