Assistance in Health Care

Application for Assistance

For the month of

PATIENT INFORMATION

PATIENT NAME | PATIENT DATE OF BIRTH

MAILING ADDRESS

CITY | STATE | ZIPCODE

EMAIL | PREFERRED PHONE | AGES OF CHILDREN LIVING IN HOME UNDER 18

FIRST TIME APPLICANT? | HOW DID YOU HEAR ABOUT US? | MAY WE CONTACT YOU ABOUT SHARING YOUR STORY?

EMPLOYMENT INFORMATION

PATIENT EMPLOYER

OCCUPATION | CURRENT MONTHLY INCOME AFTER TAXES

SPOUSE EMPLOYER

OCCUPATION | CURRENT MONTHLY INCOME AFTER TAXES

NOTES

FINANCIAL INFORMATION

Income

TOTAL MONTHLY HOUSEHOLD INCOME AFTER TAXES

Expense

TOTAL MONTHLY NON-MEDICAL EXPENSES

Net

Note: See Attachment A for full financial disclosure

VERIFICATION OF TREATMENT

PHYSICIAN NAME | FACILITY

ADDRESS | PHONE

TYPE OF CANCER | STAGE

TREATMENT PLAN | NOTES:

UNDER ACTIVE TREATMENT? | TREATMENT TYPE | NAME AND TITLE OF MEDICAL PROFESSIONAL

ELECTRONIC SIGNATURE

RELATIONSHIP TO PATIENT | PERSON COMPLETING FORM | DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

FOR OFFICE USE ONLY

☐ APPROVED ☐ DENIED **DENIAL REASON:**

NAME | SIGNATURE | DATE

NAME | SIGNATURE | DATE

NAME | SIGNATURE | DATE

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Attachment A Financial Disclosure .

Income	
Patient Monthly Income After Taxes	
Spouse Monthly Income After Taxes	
Contributer Monthly Income After Taxes	
Contributer Monthly Income After Taxes	
Contributer Monthly Income After Taxes	
Total Monthly Income	
Expense	
Monthly Rent	
Total Monthly Utilities	
Car Payments	
Monthly Home Insurance	
Monthly Car Insurance	
Monthly Gasoline	
Monthly Food	
Monthly Credit Card Bill	
Other Monthly Expenses	
Total Monthly Expense	
Net Monthly Income	
Net Monthly Income	
Patient Financial Notes:	

Official Notes: