

## 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 \_\_\_\_\_

