



CANCER FOUNDATION

# Application for Financial Assistance

## PERSONAL INFORMATION

Full Legal Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## MEDICAL INFORMATION

Type of Cancer: \_\_\_\_\_ Date of Initial Diagnosis: \_\_\_\_\_

Hospital where receiving treatment: \_\_\_\_\_

Primary Treating Physician name and phone number: \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

Does the patient have health insurance?  Yes  No

If applicable, annual deductible amount: \$ \_\_\_\_\_ Annual out of pocket maximum: \$ \_\_\_\_\_

If you have health insurance, please indicate the type of insurance (Check all that apply):

Private  Medicare  Medicaid  Medicare+Medigap  VA Program  Other (specify)

Monthly premium: \$ \_\_\_\_\_ Are prescription drugs covered?  Yes  No

## INCOME INFORMATION

Is the patient employed?  Yes  No If employed, is the patient able to work during treatment?  Yes  No

Annual household income : \$ \_\_\_\_\_ Number of people in household: \_\_\_\_\_

Family Income Sources (Check all that apply):

Patient's Earnings  Spouse's Earnings  Pension  Unemployment  Short term disability

SSD Disability  SSI  Public Assistance  Other (please specify):



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## FINANCIAL HARDSHIP INFORMATION

What will this money be used for and when is it needed by? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your situation (Why is this a financial hardship and how this grant will help you)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell us a little bit about yourself (career, interests, family, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## OTHER

May we share your story to help us promote our organization for future fundraising purposes? (Note – Your answer will not be used in our decision to make a grant)  Yes  No

### GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT A SIGNATURE

I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE AND ACCURATE.  
FURTHER, I GIVE PERMISSION FOR MY DOCTORS AND STAFF TO PROVIDE INFORMATION  
ABOUT MY CONDITION AND TREATMENT TO ME<sup>2</sup> CANCER FOUNDATION.

Applicant's Name – Printed \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_