ME SQUARED CANCER FOUNDATION

APPLICATION FOR **FINANCIAL ASSISTANCE**

PERSONAL INFORMATION

FULL LEGAL NAME OF APPLICANT

DATE OF BIRTH

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER

EMAIL

PRIMARY LANGUAGE SPOKEN

MEDICAL INFORMATION

TYPE OF CANCER

DATE OF DIAGNOSIS

HOSPITAL WHERE RECEIVING TREATMENT

PRIMARY TREATING PHYSICIAN

PHYSICIAN'S PHONE NUMBER

HEALTH INSURANCE INFORMATION

DOES THE PATIENT HAVE HEALTH INSURANCE? Yes No

IF PATIENT HAS HEALTH INSURANCE, PLEASE INDICATE THE TYPE. CHECK ALL THAT APPLY.

☐ PRIVATE ☐ MEDICARE ☐ MEDICAID ☐ MEDICARE + MEDIGAP ☐ VA PROGRAM

☐ OTHER (PLEASE SPECIFY) ____________________

ARE PRESCRIPTION DRUGS COVERED? Yes No

ANNUAL DEDUCTIBLE $ ____________________

ANNUAL OUT OF POCKET MAXIMUM $ ____________________

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 ____ HOUSEHOLD OCCUPANTS UNDER 18 ____

☐ PATIENT'S EARNINGS ☐ SPOUSE'S EARNINGS ☐ PENSION ☐ UNEMPLOYMENT ☐ SHORT TERM DISABILITY

☐ SSD DISABILITY ☐ SSI ☐ PUBLIC ASSISTANCE ☐ OTHER ____________________

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FINANCIAL HARDSHIP INFORMATION

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

Please describe your situation. Why is this a financial hardship and how will this grant help you? Will you need to travel for care, and if so, how long?

Tell us a little bit about yourself; career, interests, family, etc.

May we share your story to help us promote our organization for future fundraising purposes? Your answer will not be used in our decision to make a grant. ☐ NO ☐ YES

300 State Street #93771, Southlake Texas 76092-8777
Please return Form to: aid@mesquaredcancerfoundation.org

ME SQUARED CANCER FOUNDATION

APPLICATION FOR **FINANCIAL ASSISTANCE**

Me Squared Cancer Foundation is committed to serving the needs of ALL adult, newly diagnosed cancer patients in our service area regardless of their race or ethnicity. The following information is collected solely for demographic purposes to help us better serve cancer patients in our community and is NEVER used in the decision to provide aid.

Which one of the following best describes you? Please select one.

- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or Alaskan Native
- ☐ White or Caucasian
- ☐ Multiracial or Biracial
- ☐ A race/ethnicity not listed here
- ☐ Prefer not to answer

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT A SIGNATURE.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE AND ACCURATE. I GIVE PERMISSION FOR MY DOCTORS AND STAFF TO PROVIDE INFORMATION ABOUT MY CONDITION AND TREATMENT TO ME² CANCER FOUNDATION.

NAME OF PERSON COMPLETING FORM (PRINTED)	RELATIONSHIP TO APPLICANT	PHONE NUMBER

APPLICANT'S NAME (PRINTED)	DATE

APPLICANT'S SIGNATURE

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