275 Seventh Avenue, Floor 22, New York, NY 10001
Phone: 1-800-813-HOPE (4673) **Fax:** 212-712-8495
Email: info@cancercare.org **Web:** www.cancercare.org

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION **(please print)**

First name: ________________________ Last name: _________________________ Today's date: _______________

Address: ____ City, State, Zip: _____________________________________

Phone number: Home ( ) _________________________ Work ( ) __________________________

Cell ( )______________________ Email Address ________________________________

Date of birth: _____________ If patient is a minor (under 18), name of parent or guardian: ______________________

❑ Male ❑ Female Ethnicity: ❑ White ❑ African American ❑ Latino ❑ Asian ❑ Other ___________

MEDICAL INFORMATION **(Must be completed by nurse, doctor, social worker or ACS patient navigator ONLY.)**

Date of diagnosis: ___________ Primary cancer: ___________________ Stage _______

❑ New diagnosis ❑ Recurrence **Is patient in active treatment? ❑ Yes ❑ No**

If not in active treatment, indicate frequency of follow-up: ❑ Yearly ❑ Every six months ❑ Other_________

Please indicate type of treatment(s) received in past twelve months (check all that apply)

❑ Chemotherapy ❑ Radiation ❑ Surgery ❑Hormonal ❑ Palliative care ❑ Bone marrow/stem cell transplant

HEALTH CARE PROFESSIONAL INFORMATION **(please print):**

MD name: _______________________________ Hospital/Clinic: _________________________________

Address: ____ City, State, Zip: __________________________

Phone: ( ) _______________________ Fax: ( ) ________________________

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE **(please print):**

____

Phone: ( ) _______________________ Email: ____

Your relationship to person applying for help: ❑ Doctor ❑ Nurse ❑ Social Worker ❑ ACS Patient Navigator

Signature of MEDICAL PROFESSIONAL: __________________________________ **Date:** ____________

Please continue to back of form

APPLICANT'S NAME: ________________________________ **DOB:** ____________________

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? ❑ **Yes** ❑ **No**

If yes, please indicate type of insurance (check all that apply):

❑ Private insurance ❑ Medicaid ❑ Medicare ❑ Medicare plus Medigap ❑ Charity care ❑ VA program

Are prescription drugs covered? ❑ **Yes** ❑ **No**

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ❑ **Yes** ❑ **No**
Number of people in household: ________________

FAMILY INCOME SOURCES (please check all that apply):
❑ Social Security (retirement) ❑ Salary ❑ Pension ❑ Unemployment
❑ Public assistance ❑ Short-term disability ❑ SSD (Disability) ❑ SSI
❑ Family/friends provide support ❑ Other - specify ________________________

TOTAL ANNUAL FAMILY INCOME *: $____________ * **Application will not be processed if this information is not provided**

FAMILY ASSETS (provide total amount in all accounts apply):
Checking/Money Market: $______________ Savings/CD: $__________
IRA/403B/401K: $______________ Stocks & Bonds: $__________

TOTAL FAMILY ASSETS*: $__________________ * **Application will not be processed if this information is not provided**

FINANCIAL ASSISTANCE NEEDS **(Check all that apply):**

I need help with the following cancer-related expenses:

❑ Transportation: ❑ Child care ❑ Home care ❑ Pain medications ❑ Lymphedema supplies

Please be aware that funds are limited and based on availability. Patients must also meet Cancer*Care's* eligibility requirements. *Our grants are not for living expenses such as rent, mortgages, utility payments or food, and we do not provide grants for medical bills or insurance co-payments. If you need this type of assistance, one of our social workers may be able to refer you to a local agency for help.*

Signature: ________________________________ Date: ____________________________

Relationship to person applying for help: ❑ Self ❑ Spouse ❑ Family member/caregiver ❑ Health care professional

THANK YOU.
Fax this form to (212) 712-8495 or mail to: Cancer*Care*, 275 Seventh Avenue, Floor 22, New York, NY 10001.
Cancer*Care* will review this information and contact the person requesting financial assistance.
All information is strictly confidential and is for CancerCare use only.
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