



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

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

Date of diagnosis: Primary cancer: Stage

New diagnosis Recurrence In active treatment? Yes No

If yes, indicate type of treatment(s) received in past six months (check all that apply)

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

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

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: Date:

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 CancerCare'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: CancerCare, 275 Seventh Avenue, Floor 22, New York, NY 10001.

CancerCare 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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