Application for Financial Assistance

Instructions: If you have cancer and need financial assistance, please complete this application and return it to us with the requested supporting documents by mail, fax, or e-mail.
The patient is to fill out and sign application before submitting to the Physician for signature.

NOTE: Application should be completed in black ink

Applications will be accepted from cancer patients that receive treatment in the following states only: AL, AZ, CA, FL, IN, KY, MA, MD, MI, NC, NJ, NV, NY, RI, SC, WA & WV

4571 Colonial Boulevard
Fort Myers, FL 33966
Fax: (239) 938-9399
e-mail: info@21stcenturycare.org

If you have any questions or need assistance completing this application, please call us at (239) 936-3756.

Last Name: ________________________ First Name: ________________ DOB: ________ SS: ______________

Address: ____

City: _______________________ State: _________ Zip: ___________ Telephone: _________________________

Alternate phone: _________________________ E-mail address: ____

If the patient is under 18 years old, please provide the name of his/her parent or guardian:

Last Name: ________________________ First Name: ________________

☐ Male ☐ Employed ☐ Unemployed ☐ Caucasian ☐ Black/African American

☐ Female ☐ Disabled ☐ Retired ☐ Asian ☐ Native American

☐ Student ☐ Hispanic ☐ Other ☐ Do not wish to answer

Financial assistance is requested for:

☐ Transportation ☐ Child care during treatment ☐ Education or support meetings

☐ Respite care ☐ Temporary housing ☐ Food during treatment period

☐ Medical supplies/equipment ☐ Cancer screening ☐ Other: ________________________________

Have you applied for assistance from other sources? ☐ Yes ☐ No

If you answered yes to this question, provide organization, amount of funds received or requested (use separate sheet if necessary)

____

____

Note: We do not provide financial assistance for prescription medications, co-pays, deductibles, treatment expenses, mortgage/rent, utilities or other household expenses.

Amount requested: ________________ (If you do not have an exact amount, provide estimate)

Sources of net income in household (alimony, child support or separate maintenance income need not be revealed. Use separate sheet if necessary). Amounts must be shown. You must submit a legible and clear copy of the 1st page of your most recent tax return showing adjusted gross income and a copy of all wage statements from the previous month.

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Total approximate worth of your assets: ____________

House__________ Car__________ Savings__________ Checking__________ CDs/IRAs/etc.______________

(Use separate sheet if necessary)

Name of Applicant:____

Number of people living in your household that can be claimed as dependents on your tax return: ______

Do you have health insurance (including Medicare/Medicaid)? ☐ Yes ☐ No

Attach: ☐ Copy of social security card (Required) ☐ 1st page of tax return ☐ Wage statements

Patient/Parent signature

By signing below I authorize 21st Century C.A.R.E. to obtain and discuss information related to this application with my physician and other care providers. I certify that the above statements are true. Payment is dependent on availability of funds. Funds are not always available each month. All information related to this application will be kept strictly confidential and will not be shared with outside persons or agencies. Grants will be awarded without regard to race, national origin, gender, or sexual orientation and may be suspended at anytime due to unavailability of funds. Verification of information provided may be required.

_________________________________ _____________________

Signature Date signed

<u>All information requested must be included or the application will not be considered</u>

---------------------------------- This section to be completed by the patient's doctor ----------------------------------

Patient's diagnosis: _________________ Date of diagnosis: _________________

Is the patient in active cancer treatment, within 6 months of a diagnosis of cancer, within 6 months of completing treatment, in need of cancer screening and in need of financial assistance (Required) ? ☐ Yes ☐ No

Physician Name: ____

Hospital/Clinic: ____

Address: ____

City: _______________________ State: ________ Zip: _________ Phone: _________________

Comments:

Office contact name: _____________________________________ Phone: _______________

Physician signature: _____________________________________ Date: ________________
(Required)

-- For internal use only --

Financial assistance committee review: ☐ Approved ☐ Not approved

Date approved: ____/____/____ By: ___________________________________

Date approved: ____/____/____ ___________________________________

Date approved: ____/____/____ ___________________________________

Amount approved: $______________ ___________________________________

Outcome/comments: