The Cancer Foundation of Northeast Georgia

Application for the Financial Assistance Program

All requests for funding must be presented in writing using this form. Please include any other supporting documents.

Date of Application: ____________ ☐ Male ☐Female

Applicant's name:_______________________________________ D.O.B____________________________

Check one of the following: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Number of person(s) dependent on income (excluding yourself):______________

What type of cancer do you have :_________________________ Date of Diagnosis:__________________

Are you currently receiving treatment? ________ Who is your oncologist: _______________________________

If you are not currently in treatment when was your last treatment? ____________________________

Address:____

City/State/Zip: ____ County:____________________

Phone Number:__________________________________ Email:____________________________

Amount Requested:_________________

Have you ever received financial assistance from the Cancer Foundation of NEGA? ☐ Yes ☐ No

What is it that you need assistance with? ____

____

Why do you need this? ____

____

List other agencies you have contacted for help and when:____

____

Monthly Household Gross Income		**Monthly Household Expenses**	
Cash	$	Rent/Mortgage	$
Wages (pre-deductions)	$	Utilities	$
Social Security	$	Groceries/Food	$
Disability	$	Transportation	$
Unemployment	$	Car Payment	$
Retirement/Pension	$	Out of Pocket Medical Expenses	$
Other	$	Other Expenses	$
Total	$	**Total**	$

Household Resources	
Checking	$
Savings	$
Money Market	$
Stocks/Bonds	$
C.D'S	$
Mutual Funds/ Taxable Annuities	$
Other	$
Total	$

All the information I have provided is true and correct. I understand that any financial assistance provided by the Foundation is provided directly to my creditors, is limited, and is based on the immediate needs that negatively impact my health status. Application will expire 60 days from date of the application. Providing false information will result in denial of assistance.

I authorize the Foundation to contact my health care provider(s) listed above, and I authorize my health care provider(s) to release information to the Foundation related to this application. If requested by my health care provider(s), I will complete an appropriate authorization to allow him/her to release information to the Foundation pertaining to this application. All information provided to the Foundation will remain confidential, except that the Foundation may disclose information to my creditors and others as may be necessary to provide financial assistance.

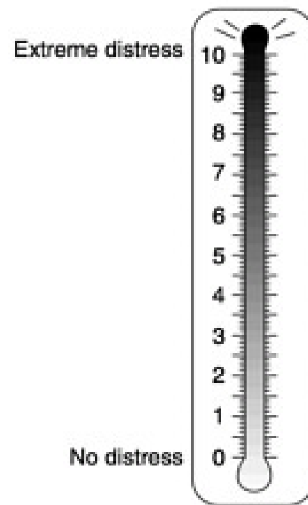
I understand that although the Foundation may consider billing cycles and due dates when providing financial assistance, I remain fully responsible for timely payments of my debts, and I will indemnify and hold harmless the Foundation for any expenses, losses, or liabilities arising from or related to my debts.

______________________________ ______________________________

Applicant's Signature **Date**

Cancer Foundation of Northeast Georgia
Financial Distress Screening

First, please circle the number on the scale that best describes how much financial distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	<u>Financial Problems</u>
□	□	Prescription coverage/co-payments
□	□	Past due utilities
□	□	Past due rent/mortgage
□	□	Insurance premiums
□	□	Insurance co-payments
□	□	Nutritional assistance
□	□	Durable Medical Equipment (not covered by insurance)
□	□	Transportation costs
□	□	Other:____

____