

To be completed by referring professional:

What are the special/extenuating circumstances causing this family to seek financial assistance?

Please pick the category that best describes how this request benefits the individual?

| | |
|--|--|
| Pay for pharmacy prescriptions not covered by insurance | Insurance co-payments (does not include co-insurance or deductibles) |
| Pay past bills for gas, electric, water, propane and phone | Nutritional Assistance |
| Pay past due rent/mortgage payments | Durable Medical Equipment (not covered by insurance) |
| Insurance premiums [COBRA]premiums included | Transportation costs (gas cards) |

To whom and where should the assistance be directed? _____

Check made payable:

To Attention of: _____

To Attention of: _____

Acct No: _____

Acct No: _____

Mail Check to: _____

Mail Check to: _____

To Attention of: _____

To Attention of: _____

Acct No: _____

Acct No: _____

Mail Check to: _____

Mail Check to: _____

I reviewed this application and I agree with the funding need.

Referring professional -Print Name & Date

Referring professional -Signature

Phone: _____

Fax: _____

Please email or fax this form to kliebowitz@negacancer.com or 706-353-4353

Foundation Use Only:

Print Name & Date

Signature

Check No: _____

Check Amount: _____

Check Date: _____