citrusAID
CANCER FOUNDATION

REQUEST FOR PATIENT FINANCIAL ASSISSTANCE

Patient: _____ _____
First Name Last Name

Address: _____
Street/P.O. Box

_____ _____ _____ (____) _____
City State Zip Phone

Patient Information:

Gender: ☐ Male ☐ Female Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Does he/she have health insurance? ☐ Yes ☐ No Type of insurance: _____

Diagnosis: _____

In Active Treatment? Yes ☐ No ☐ Date of Original Diagnosis: _____

Oncologist: _____

Source of Income:

☐ Salary ☐ Unemployment Benefits ☐ Pension ☐ TANF ☐ Social Security Retirement
☐ Long Term Disability ☐ Short Term Disability ☐ SSI ☐ SSDI ☐ Child Support
☐ In-Kind (room and board) ☐ Alimony ☐ Family/Friends provide support
☐ Other _____

Number of people in the household: ___ Any Minor Aged Children? ☐ Yes ☐ No

Type of assistance requested: _____

Request made by: ☐ Patient ☐ Spouse ☐ Parent ☐ Sibling ☐ Friend

☐ Other _____

Referred by _____

_____ _____
Signature of Intake Person Date

522 N Lecanto Highway
Lecanto, FL 34461
352-527-0106

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CANCER FOUNDATION

APPLICATION FOR FINANCIAL ASSISTANCE

ONLY FULLY-COMPLETED APPLICATIONS WILL BE PROCESSED

Date _____

Section 1: PATIENT INFORMATION

Last Name _____ First Name _____

Address _____ City/Zip _____

Phone Home ( )_____Work ( )_____ Cell ( )_____

Email _____ Male ( ) Female ( ) Birthdate_____

Number of persons living in your household including non-family and children _____

Section 2: FINANCIAL INFORMATION

EXPENSES

Monthly Family Expenses	Amount	Family Assets/Monthly Income	Amount
Rent/Mortgage	$	Checking	$
Phone	$	Savings and/or Money Market	$
Home: electric	$	Investments	$
Home: gas	$	Salary	$
Home: water	$	Pension	$
Cable	$	Alimony	$
Child Care	$	SSR	$
Transportation	$	SSI/SSDI	$
Health Insurance	$		
Medical Bills	$		
Food	$		
Other (specify)	$	Other (specify)	
Monthly Expenses Total	$	**Family Assets Total**	

INCOME

PLEASE CHECK ALL THAT APPLY AND ATTACH COPIES OF INCOME DOCUMENTATION FOR EACH APPLICATIONS WITHOUT DOCUMENTATION WILL NOT BE PROCESSED

( ) Pension	( ) Public Assistance	( ) Salary
( ) Social Security (retirement)	( ) Previous Year Tax Return	
( ) SSI/SSDI	( ) Alimony	
( ) Other: Specify		

1. To what other organizations have you applied for financial assistance? _____
2. Are you now or will you be receiving assistance from another organization(s)? ( ) YES ( ) NO
3. If YES, provide details and amount _____

Section 3: ASSISTANCE NEEDED

1. Household Expenses and Assets: PLEASE ATTACH THE FOLLOWING
    a. Copies of current bills for items you would like to receive financial assistance. Please continue to pay any bills until you receive notification of approval.
    b. Verification of household assets – most recent bank statements for 3 months and SSI letters for applicant, your spouse and other household members living with you (if applicable).
    c. If requesting rent assistance, please attach a copy of your rental agreement.
    d. If requesting mortgage assistance, please attach a copy of your latest mortgage statement.
        i. Please list the expenses for which you are applying for assistance.

Item	Cost	Comments
AUTO		
RENT		
MORTGAGE		
UTILITY		
OTHER		

ADDITIONAL COMMENTS:

_____

_____

_____

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522 N Lecanto Hwy
Lecanto, FL 34461

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GENERAL RELEASE

I/We understand that our participation in the CITRUS AID CANCER FOUNDATION is voluntary and these benefits are a humanitarian endeavor to provide financial support to patients who are battling cancer who are experiencing financial difficulties.

I/We hereby release, discharge, and agree to hold harmless Citrus Aid Cancer Foundation, its officers, directors, agents, sponsors, medical advisors, volunteers and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by the Citrus Aid Cancer Foundation.

I/We release authority to gather medical information and records requested as to my condition.

Last 4 Digits of Social Security Number _____

Home Address _____

Signature_____

Print Name_____

Date _____

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