CANCER ALLIANCE OF HELP & HOPE, INC.

CAHH Use Only:
Date: _____ **Amount Approved:** _____
Approved by: _____

Patient Application for Financial Assistance

PLEASE PRINT

Date _____

Name (First, Middle, Last) _____

Address _____

City, State, Zip _____

Phone _____ Email _____

Date of Birth _____ Social Security # _____

Gender_____ Ethnicity_____

Spouse Name _____ Roommate or Significant Other _____

Children (living at home) names and ages _____

Household Monthly Income

Applicant — Employer's Name _____
Monthly Income $ _____

Spouse / Partner — Employer's Name _____
Monthly Income $ _____

All Individuals 21 years of age, or older, living with Applicant
Employer's Name _____
Monthly Income $ _____

Other Income: Child Support, Alimony, Public Assistance, Social Security, Pension, Self-Employed, Business Owner
Source of Income _____
Monthly Income $ _____

Bank Accounts (Savings / Checking / Money Market / CDs / IRA)

Applicant — Bank Name _____
Balance of Last Statement $ _____
Bank Name _____
Balance of Last Statement $ _____

Spouse / Partner — Bank Name _____
Balance of Last Statement $ _____
Bank Name _____
Balance of Last Statement $ _____

Assets (House / Other Real Estate / Car / Boat)

Applicant — House (address and $ value) _____
Car(s) (Make/Model/Value) _____
Other _____

Spouse / Partner — Car(s) (Make/Model/Value) _____
Other _____

Monthly Expenses

Applicant	Mortgage / Rent	$_____	Other	$_____
	Utilities	$_____	Health Ins.	$_____
	Food	$_____	Hospital Bills	$_____
	Car payment	$_____	Treatments	$_____
	Car Insurance	$_____	Prescriptions	$_____
	Loans	$_____	Other Medical	$_____
	Credit Cards	$_____		

Type of Cancer _____ Diagnosis Date_____

Referred By _____

Treating Physician _____ Address _____ Phone _____

Do you have Health Insurance? _____

Specify the type of assistance being requested: (Check all that apply)

☐ Utilities ☐ Health Insurance ☐ Car Insurance ☐ Rent/Mortgage ☐ Car Payment

Explanation of Need

Include a detailed explanation of the circumstances which require you to request financial assistance.

_____

_____

_____

_____

☐ **Please check box if you are willing to share your story and give a testimonial. This will have no bearing on approval of your application.**

Should your application be approved, please list in order of priority those bills you wish CAHH to pay. Checks cannot be made payable to the applicant.

1) _____

2) _____

3) _____

4) _____

Please check off and attach copies of the following:

☐ **Copy of last year's tax return**

☐ **Physician's Statement of Treatment**

☐ **Proof of Palm Beach County residency (I.e. lease agreement, deed, etc.)**

☐ **Copy of bills (invoices) that you wish to be paid**

☐ **Copy of photo ID**

☐ **Copy of last 2 months bank statements**

I certify with my signature that to the best of my knowledge the financial information I have provided is complete and accurate. I understand that the information I have given is subject to verification by the Cancer Alliance of Help and Hope. I also understand that I am responsible to inform CAHH of any change in my financial status. I grant permission to CAHH to use my information submitted and disclose to other agencies, providers, doctors and medical facilities requesting this information. Information may be shared verbally or by email or mail.

_____ _____

Applicant Signature **Date**

Please submit application and attachments to:

Cancer Alliance of Help and Hope, Inc., P.O. Box 3292, Palm Beach, FL 33480

Phone: 561-748-7227 Email: cancerallliance@gmail.com