**For Office Use Only**

□ CC Cancer Fund

□ GC Cancer Fund

□ Jan Koweek Fund

□ Dyson Foundation

□ Comp. Ther. Fund

**Request for Financial Assistance**

**Date:**

**Date of Birth:**

**Name:**

**Address: Phone Number:**

**Family member with cancer:**

□ **Self**

□ **Spouse**

□ **Child**

□ **Not Applicable**

**Type of expense you need assistance with:**

□ **Medical bills/co-payments**

□ **Prescriptions**

□ **Transportation**

□ **Utility bills**

□ **Food**

□ **Undergoing diagnostic testing**

□ **Health insurance**

□ **Other:**

**Total monthly income from all sources:$ # of people in household\_\_\_\_\_**

**Total Assets-(savings, checking, retirement accounts):$**

**Do you have health Insurance? Yes/No**

 **If yes, what type?**

**If no, have you applied for Medicaid or Family Health Plus? Yes/No**

 **Status:**

**Have you applied for Disability? Yes/No**

 **Status:**

**Have you applied for or are you receiving food stamp benefits, cash assistance or HEAP through the Department of Social Services? Yes/No**

 **Application is still pending:**

**If yes, what is the amount received for:**

 **Food stamps? $**

 **Cash Assistance? $**

 **HEAP? $**

**What is the funding requested for? Briefly describe the financial hardship that you are**

**Experiencing at this time.**

**Amount requested from fund: $**

**Pay to vendor:**

**Address:**

**\*In order to consider your request, we *must* have a copy of bill from vendor. Once all**

**documents are received, applicant will be notified of approval/decline within 1 week.**

**Signature of Applicant: Date:**

**Send to: The Healthcare Consortium**

 **325 Columbia Street**

 **Hudson, NY 12534**

 **ATTN: L. Scheer**

**Decision:**

**Date:**

**P/O #**