**Application for Financial Assistance**

**Date of application:**

**Name of applicant:**

(The applicant is the person with cancer for whom assistance is requested)

**Address:**

**Home Phone #: Cell Phone #:**

**Email address:**

**Date of Birth: Age:**

**Name of person completing form (if different from applicant):**

**What is the relationship of the person completing the form to the applicant?**

□ Self

□ Spouse

□ Child

□ Other:

**What are the types of expenses for which financial assistance would be used?**

□ Health insurance premiums

□ Medical bills (deductibles, co-payments, co-insurance)

□ Prescription medications

□ Transportation expenses (e.g. gas, train tickets, etc.)

□ Rent or mortgage payments

□ Utility bills

□ Food

□ Other:

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

**Total Assets (sum of balances in savings, checking, and retirement accounts): $**

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

If “**Yes,**” what type?

If “**No**,” have you applied for Medicaid or other health insurance? Yes/No

  If you have applied, what is the status of that application?

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

If you have applied, what is the status of that application?

(**PLEASE CONTINUE TO BACK OF THIS PAGE)**

**Are you receiving SNAP benefits (food stamps), cash assistance and/or HEAP through the Department of Social Services? Yes/No**

If “**Yes**,” what is the amount received for:

SNAP (food stamps) $

Cash Assistance $

HEAP $

If “**No**,” have you applied? Yes/No

If you have applied, what is the status of that application?

**Why are you applying for Financial Assistance at this time? Please briefly describe the financial hardship that you are experiencing.**

**Amount requested from the fund: $ (**up to $1,000 in Columbia; up to $750 in Greene**)**

**PLEASE NOTE: Financial assistance is not provided as cash to the applicant. Instead, payment of all bills is made directly to the vendor (health insurance carrier, healthcare provider, landlord, etc.).**

***With my signature below, I attest that all information provided on this form is true and accurate.***

**Signature of Applicant: Date:**

**Send to: The Healthcare Consortium**

**325 Columbia Street, Suite 200**

**Hudson, NY 12534**

**ATTN: L. Scheer**

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**Determination of the Application Review Committee:**

**If assistance will be provided, what is its source?**

□ CC Cancer Fund □ GC Cancer Fund □ Jan Koweek Fund □ Dyson Foundation □ Comp. Ther. Fund

**If assistance will be provided, what is the associated P/O #? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**