



# Application for Financial Assistance

Important: Applying for assistance ***does not*** guarantee said assistance. While our goal is to help as many families as possible, all financial applications will be reviewed on a case-by-case basis and final determination will be made based upon other applications submitted and the availability of funds.

## Patient Data:

Patient's Name (first, middle, last)	
Street Address	
City, ST, ZIP Code	
Home Phone	
Cell Phone	
E-Mail Address	
Gender Male/Female	
Age	
Date of birth	

## If patient is less than 18 years of age:

Legal Guardian's Name	
Relationship to Patient	
Marital Status	
If divorced, who has custody of the patient/child?	
	<b>IF PARENTS/GUARDIANS DO NOT RESIDE IN THE SAME HOUSEHOLD AND ARE BOTH SEEKING FINANCIAL ASSISTANCE, BOTH PARENTS/GUARDIANS MUST FILL OUT AN APPLICATION.</b>
Is address same as pt.?	
Street Address	
City, ST, ZIP Code	
Home Phone	
Cell Phone	
E-Mail Address	
Do parents/guardians speak English?	
If no, primary language?	

**Medical Information: This section must be filled out by hospital personnel (Physician or Social Worker)**

Type of Cancer (diagnosis)	
Date of Diagnosis	
Physician's Name	
Physician's Address	
City, ST, ZIP Code	
Office Phone	
Fax Number	
E-Mail Address	
Social Worker Name	
Social Worker Address	
City ST ZIP Code	
Office Phone	
Fax Number	
E-Mail Address	

**Financial Information:**

Approximate Household Income:	
Is patient/parent/guardian on unpaid leave due to illness?	
Number of people living in the home:	
Is assistance being provided from another organization? If yes, please list name of organization and type of assistance.	
<b>Organization</b>	<b>Type of assistance</b>

### **Needs for Assistance Essay:**

Please summarize a short history of the illness, about the patient, how the illness has affected you and/or your family and what kind of assistance you are requesting. E.g. Mortgage/Rent, Insurance Premiums (Auto/Homeowners), Utilities, Household Expenses, Car Payment, Auto Expenses. (Attach separate sheet for additional space)

**Important Notice Please Read:**

Show Me A Cure is a 501(c)3 charitable organization dependent upon the public for support. Show Me A Cure maximizes the limited resources available. Show Me A Cure reserves the right, in its sole discretion, to modify the same at any time without notice.

You will not be discriminated against or denied aid because of your race, religion, color, national origin, sex or political affiliation.

All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted and the availability of funds.

The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

**Consent to Release Information and Affirmation:**

I do hereby authorize all financial institutions to release to Show Me A Cure, or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize Show Me A Cure and its representatives to provide such information to those institutions as may be reasonably required to assist our family and/or child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

As an inducement to Show Me A Cure, a 501(c)3 non-profit organization, to advance supplemental family support expenses in conjunction with the medical treatment of \_\_\_\_\_

Undersigned to hereby affirm as follows:

1. The undersigned is the patient or the parent(s) or guardian(s) of the child.
2. The term "non-medical expenses" is understood to mean those reasonable and necessary expenses incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided, with the use of said funds to be specified by Show Me A Cure.
3. The undersigned further agree(s) to return any unused funds immediately to Show Me A Cure so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledge(s) and agree(s) to maintain records that will be made available to Show Me A Cure upon reasonable request, detailing the expenditures made from the funds provided by the organization.

Show Me A Cure will pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_

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Patient	Mother/Guardian Signature	Father/Guardian Signature
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Please Print Name	Please Print Name	Please Print Name
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**Witness:**

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## Release/Consent Form:

I hereby give my permission for Show Me A Cure and/or its representatives to use artwork, photographs and/or letters that I provide of myself, my family, or my child in publications, slides, videotapes, motion pictures or on the Internet. In addition, I hereby give my permission for Show Me A Cure and/or its representatives to photograph, audio tape record, or videotape my child or myself and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet.

I understand these visual images or voice recordings may be used to inform families, volunteers, donors, the media and general public about Show Me A Cure programs, services or events.

I gladly give this authorization to support the efforts of Show Me A Cure. I understand this authorization shall continue until terminated in writing.

***Signing the consent form is not a requirement in order to receive assistance from Show Me A Cure.***

Please Print Clearly Name/Child's Name:		Date of Birth:
Street Address:		
City:	State:	Zip:
Phone:	Cell:	Fax:
Email:		

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Parent/Guardian signature required for minors)

Show Me A Cure's  
**Helping Hand**

**Letter Of Support:**

*To be filled out by a Physician or Social Worker.  
(Note: Attach separate sheet for additional space)*

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Referring Physician/Social Worker (PRINT)

Hospital

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Physicians/Social Worker email address

( )  
Physician/Social Worker Phone

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Physicians/Social Worker Signature

Date

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Patient's Name

Date of Birth

Phone

How long have you been working with the patient?

Please **type** a brief description of the patient's current medical condition and the next 60 days treatment plan: