Giving Direct Financial Assistance to LOCAL Families battling Cancer or Leukemia Since 2009.

APPLICATION FOR ASSISTANCE

(Confidential information will only be viewed by C4AC board members)

Date: _____ How did you hear about C4AC: _____

Patients Name: _____

Patients Date of Birth: _____ Patients Gender: Male Female (Please circle one)

Patients address: _____

_____ _____ _____

(City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____

Married: _____ Single: _____ Minor/Child _____ (Please check one)

If a minor, please give Parents/Guardians Full Names: _____

_____

Is patient currently employed: _____ If yes, where: _____

If married, is spouse employed: _____ If yes, where: _____

Total Monthly household income: _____

Do you currently received any other assistance of **ANY** kind:_____ If yes, from where and how much:

_____

_____

Do you currently have insurance? Yes or No (Please circle one)

If yes, who is your insurance provider: _____

Children: Yes or No (Please circle one) If yes, how many? _____

If you circled yes, please list ages of each child & if do they live at home:

Ages:	Do they live at home:
_____	_____
_____	_____
_____	_____
_____	_____

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MEDICAL INFORMATION: (Must have letter from treating Physician or Social Worker that shows diagnosis and date)

Patients Official Diagnosis: _____

Date of Diagnosis: _____

Treating Physician's Name & Address: _____

_____

Hospital/Clinic you are receiving treatment at: _____

Have you been assigned a Social Worker at the hospital? Yes or No (Please circle one).

If yes, please list name and phone number: _____

_____

Although patients may have insurance, we understand that everyday bills and needs are not covered under insurance plans. I.e., Utility bills, groceries, & travel expenses that incur to and from Doctor and Hospital visits. Please give a brief statement of your situation, and what your financial needs are in the below area so that we can better evaluate your needs. You may also, attach a typed statement instead of writing below.

_____

_____

_____

_____

_____

_____

_____

_____

Please submit a letter from Physician or Social Worker that shows diagnosis & date of diagnosis along with this application to:

costumesforacause@yahoo.com

Or Mail it to:

C4AC

P.O. BOX 10680

GULFPORT, MS 39505

Once application and letter from Physician or Social Worker has been received, you will hear from us with-in 7 days.