Date: _______________

Section A: Patient Information

Name: ____

Address: ____

City: ___________________________ State: _________ Zip: ______________

Home Phone: ___________________ Cell/Work Phone: ________________________

Email Address: _________________________________

Section B: Financial Information

Please answer the following questions:

1. What is your monthly household income including but not limited to your salary, state aid money, spouse's income, rental income, retirement, and dividends? $____________

2. Please list your monthly expenses including all debts, mortgage, rent, car, utilities, etc. $___________

3. Do you have medical insurance? Yes or No

4.a. Have you received financial support from another organization? Yes or No
If yes, how much? $___________

4.b. If yes, from whom? ____

5.a. What is the approximate amount of financial assistance you are requesting from the Jill Paolucci Memorial Coalition Against Cancer? $___________

5.b. Please describe how these funds will be used:

Section C: Medical Information

1. What type of cancer do you have? ____

2. What was your approximate diagnosis date? ______________________________________

3. What is the name of your doctor? ____

4. What is the name and address of your doctors cancer center or hospital?

I, ___________________________, have contacted the Jill Paolucci Memorial Coalition Against Cancer for financial assistance related to the treatment of cancer. I certify that all statements made in this document are factual. I certify that any funds provided from the Jill Paolucci Memorial Coalition Against Cancer will be used solely for their intended purpose.

Name (Print): _________________________________

Signature: _________________________________ Date: ______________

Please return this form to: **Jill Paolucci Memorial Coalition Against Cancer**

45 Snowberry Road Malta, NY 12020

If interested, you may scan this document and send it to **dpaolucci226@yahoo.com**