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 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: ____________________________________

<u>If patient is a minor, please use parents information below:</u>

Is patient currently employed: ____________ If yes, where: ________________________

If married, is spouse employed: ___________ If yes, where: ________________________

Total Monthly household income: ____

Total monthly household expenses: ____

Do you currently received any assistanceof **<u>ANY</u>** 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, date of diagnosis, current treatment plan)

Patients Official Diagnosis: ____

Date of Diagnosis: ____

Are you still receiving treatment?__________ If no, when was your last treatment:______________

Hospital/Clinic you are receiving treatment at: ________________________________

Treating Physician's Name & Address: _______________________________________

____

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

If yes, please list name and phone number: _____________________________________

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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.

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PLEASE MAKE SURE YOU HAVE INCLUDED THE FOLLOWING WITH SUBMISSION OF APPLICATION:

PLEASE USE THIS CHECK LIST

______ **ALL** questions have been answered

______ Letter from Physician or Social Worker.

______ Does letter state the date of diagnosis?

______ Does the letter state official diagnosis?

______ Does the letter state treatment plan?

If any questions were skipped or letter from Physician or Social Worker is not attached to application, your application can't be processed.

Submit Application & letter to:

costumesforacause@yahoo.com

OR

Mail it to:

C4AC

P.O. BOX 10680

GULFPORT, MS 39505

Once application received, you should hear from us with-in 7 days.

Thank you and God Bless!