Office Use Only:

Month of Request _____ Demonstrated Need _____ Amount Approved _____
Check Issued _____ Reason for Denial _____ Denial Letter Sent _____

Assistance in Health Care
Helping cancer patients walk taller

P.O. Box 700392
Tulsa, OK 74170-0392
tel 918-286-5699
fax 918-249-7511
web assistanceinhealthcare.org

Application for Assistance

Form must be completed in full and returned by the last day of the month for consideration, including verification of treatment completed by your treating medical professional. New applications will need to be submitted each month you would like assistance. Request cannot be granted if application is incomplete. Be sure to include area codes and zip codes. **Please print legibly.**

First time applicant ____ yes ____no How did you hear about us? _____

Patient's name (please print)_____ Date of birth _____

Preferred phone _____ Email_____

Mailing address _____

City, State, Zip _____

Requesting assistance for (**non-medical** expenses only & attach applicable bills ie utilities, car, rent, food, etc) _____ Amount requested _____

Person completing form & relationship to patient _____

Income

Number of adults (18 or older) living in the household _____

Ages of dependent children living in the household _____

Others financially dependent on applicant not in household, please explain _____

Patient employer/occupation & income (include disability or SSI)_____

Spouse employer/occupation & income (include disability or SSI)_____

Other adults in household financial contributions (if not contributing financially, please explain):

Relationship to applicant, amount & source of income _____

Relationship to applicant, amount & source of income _____

Total monthly household income **AFTER** taxes _____

Has income been reduced as a result of treatment? If so, by how much?_____

Notes _____

Expenses

Rent/Mortgage _____ Combined Monthly Utilities _____ Car Payment/s _____

Home Insurance (If not included in mortgage pymt) _____ Car Insurance _____

Monthly Gasoline _____ Monthly Food/Groceries _____ Min. Credit Card Pymts _____

Specify Other Monthly Expenses _____

Total Monthly Expenses (Excludes medical) _____ Notes _____

_____

May we contact you about sharing your story? _____ yes _____ no *Stories will be shared with AHC supporters and will not impact your request for assistance in any way; only first names and last initials will be used.

Verification of Treatment

Request cannot be granted without verification by a medical professional.

This section must be completed in full by a member of your medical team.

I authorize a member of my medical team, i.e. physician, nurse, social worker to release the following information to Assistance In Health Care, Inc.

Patient Signature _____ Date _____

Type of Cancer _____ Stage _____

Under Active Treatment? yes / no - If no, is it because patient is too ill for treatment? yes / no

Current Month Treatment Dates _____ Treatment Type (Circle)

Chemo Radiation Surgery Transplant Follow-Up Only (no active treatment)

Treatment Plan _____ Notes _____

Treating Physician (Please Print) _____ Facility _____

Phone _____ Address _____

Signature _____ Date _____

Print Name and Title _____

Due to the high volume of applications received, we have maximum limits on support provided to each recipient. **Incomplete and/or late applications cannot be considered; please be sure that all questions are answered and treatment is verified**. Applications may be faxed or mailed to address above or emailed to patientassist@assistanceinhealthcare.org. All applications received will be reviewed and will receive a response either in the form of a check or a letter explaining reason for denial. Assistance in Health Care, Inc. is a nonprofit organization providing support to cancer patients undergoing active treatment in the Tulsa, OK area based on information provided in application and available funds. **Submitting an application does not ensure assistance will be provided.**