



[www.ovariancancerfoundation.org](http://www.ovariancancerfoundation.org)

# APPLICATION FOR FINANCIAL ASSISTANCE

*"Family, friends and community unite to fight ovarian cancer"*

## **APPLICANT CONTACT INFORMATION – PLEASE PRINT**

DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTRY: \_\_\_\_\_ HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

WORK: ( \_\_\_\_\_ ) \_\_\_\_\_ CELL: ( \_\_\_\_\_ ) \_\_\_\_\_

EMAIL: \_\_\_\_\_

WHICH METHOD DO YOU PREFER TO BE CONTACTED (CIRCLE ONE): HOME PHONE/WORK/CELL/EMAIL

## **APPLICANT PERSONAL INFORMATION – PLEASE PRINT**

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

EDUCATION (PLEASE CIRCLE): HIGH SCHOOL DIPLOMA/GED – COLLEGE - ASSOCIATES/BACHELOR/MASTER/DOCTORATE

OCCUPATION: \_\_\_\_\_ EMPLOYED? YES \_\_\_\_\_ NO \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_ YEARS EMPLOYED: \_\_\_\_\_

ADDRESS OF EMPLOYER: \_\_\_\_\_ PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

ANNUAL INCOME: \$ \_\_\_\_\_ TOTAL OF ADDITIONAL INCOME SOURCES/ASSISTANCE/SUPPORT: \$ \_\_\_\_\_

## **APPLICANT HOUSEHOLD INFORMATION – PLEASE PRINT**

DO YOU LIVE IN: APARTMENT / HOME / CONDO / WITH RELATIVES OR FRIENDS / PUBLIC HOUSING / SHELTER

RENT: \$ \_\_\_\_\_ MORTGAGE: \$ \_\_\_\_\_ DO YOU OWN A CAR: YES \_\_\_\_\_ NO \_\_\_\_\_ MONTHLY CAR PAYMENT \$ \_\_\_\_\_

TOTAL MONTHLY UTILITY EXPENSES (WATER/POWER/PHONE/CABLE): \$ \_\_\_\_\_ INSURANCE PREMIUM: \$ \_\_\_\_\_

CURRENT MARITAL STATUS - CIRCLE ONE: MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED / OTHER

NAME OF SPOUSE/GUARDIAN/CAREGIVER (CIRCLE ONE): \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN APPLICANT): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SUPERVISOR \_\_\_\_\_ #YEARS \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

# OF MINOR CHILDREN OR OTHER DEPENDENTS LIVING WITH YOU FULL TIME: \_\_\_\_\_ AGES: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

NUMBER OF ADULTS IN HOUSEHOLD: \_\_\_\_\_ DO THEY CONTRIBUTE TO HOUSEHOLD EXPENSES: YES \_\_\_\_\_ NO \_\_\_\_\_

**APPLICANT HEALTH INSURANCE INFORMATION – PLEASE PRINT**

INSURANCE PROVIDER: \_\_\_\_\_

ADDRESS OF PROVIDER: \_\_\_\_\_

PHONE: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

TYPE OF POLICY (CIRCLE ONE): INDIVIDUAL / FAMILY / CORPORATE / GOVERNMENT / OTHER

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

DO YOU HAVE DISABILITY INSURANCE: YES \_\_\_ NO \_\_\_ LIFE INSURANCE: YES \_\_\_ NO \_\_\_

MONTHLY PREMIUM AMOUNT \$ \_\_\_\_\_ OTHER INSURANCE: \_\_\_\_\_

**APPLICANT MEDICAL INFORMATION – PLEASE PRINT**

DATE OF DIAGNOSIS: \_\_\_\_\_ PRIMARY CANCER: \_\_\_\_\_

STAGE OF CANCER: \_\_\_\_\_ NEW DIAGNOSIS \_\_\_\_\_ REOCCURENCE \_\_\_\_\_

IS APPLICANT IN ACTIVE TREATMENT: YES \_\_\_ NO \_\_\_

IF YES, PLEASE EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

IF NO, IS POST FOLLOW UP TREATMENT NEEDED: YES \_\_\_ NO \_\_\_

IF YES, PLEASE INDICATE TYPE OF FOLLOW UP: YEARLY / SIX MONTHS/ OTHER: \_\_\_\_\_

NAME OF APPLICANT'S PHYSICIAN: \_\_\_\_\_

NAME OF HOSPITAL OR CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

EMAIL: \_\_\_\_\_ FAX: \_\_\_\_\_

**APPLICANT AUTHORIZATION, RELEASE OF INFORMATION AND REQUEST FOR FUNDS**

I \_\_\_\_\_ HEREBY AUTHORIZE REPRESENTATIVES OF THE CELMA MASTRY OVARIAN CANCER FOUNDATION TO CONTACT THOSE PHYSICIANS AND MEDICAL PROFESSIONALS AND INSTITUTIONS INVOLVED WITH MY HEALTH CARE AND AUTHORIZE THEM TO RELEASE ANY AND ALL INFORMATION REGARDING MY CONDITION AND HEALTH STATUS. I ALSO ATTEST THAT THE INFORMATION SUBMITTED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND FORMALLY REQUEST THE AMOUNT OF \$ \_\_\_\_\_ FROM THE FOUNDATION FOR MY \_\_\_\_\_ EXPENSES. ALL INFORMATION SUBMITTED IS CONSIDERED CONFIDENTIAL AND WILL ONLY BE USED BY THE FOUNDATION AND ITS MEMBERS TO DETERMINE ELIGIBILITY OF APPLICANT.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR FOUNDATION AND /OR WHO REFERRED YOU TO US? \_\_\_\_\_