505 E Perkins Avenue
Sandusky, OH 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Financial Assistance Application

Name:			Date of Birth:
Address:			City:
State:	Zip Code:	County: ☐ Erie ☐ Huron ☐ Ottawa	
Phone:	Number of people in the household: ________		

Monthly Household Income: Please provide income for yourself and spouse. Please attach copies of your proof of income documents. (See documentations checklist).

Income and Employment Status:

Applicant's current employer**:** ____

Occupation: ______________________________ Date of employment: __________to_____________

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) ____

Spouses/Partner's current employer: ____

Occupation: ______________________________ Date of employment: __________to_____________

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) ____

Monthly Gross Income	**Self**	**Spouse**	**Total Income**
Wages/self-employment	$	$	
Social Security	$	$	
Pension or retirement income	$	$	
Unemployment	$	$	
Workers' compensation	$	$	
Other income	$	$	
Total Monthly Family Income	**$**	**$**	

Type of Cancer: ____ Stage_____________

Are you receiving? ________Chemotherapy ________Radiation _______ Immunotherapy _______ Other

A current oncologist treatment plan/doctors' notes reflecting the most current diagnosis and treatment plan must be included with the application or the application will be considered incomplete.

What other agencies are you currently working with? (For example, Serving our Seniors, Job and Family Services, Care & Share, Cancer Tees Me Off, or When Pigs Fly)

Description of Need: What will the funds be used for?

Additional Comments:

I, ____, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the Cancer Services Financial Assistance Program.

Signature____ **Date:** ____________________

Relationship to applicant: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member
☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider
☐ Other (please specify): ____

Office Use Only	
Amount Approved:	Date of Approval: