275 Seventh Avenue, 22nd Floor, New York, NY 10001
Phone: 212-712-8080 or 1-800-813-HOPE Fax: 212-712-8495
Website: www.cancercare.org Email: info@cancercare.org

Financial Application

To Be Completed by Person Requesting Assistance

Personal Information
(Please Print)

Last Name:_________________________First Name___________________ Date: __________

Address: __________________________________City/State/Zip: _______________________

Phone: Home ( )_______________________Work: ( )__________________________

Date of Birth: ______________________ Age: _______ Ethnicity ____________________
(Please specify)

❑ Male ❑ Female

For Cancer*Care* Use Only:

Cancer*Care* # _________________________

Social Worker: _________________________ Case Manager: _________________________

Health Insurance Information

Do you have health insurance? ❑ Yes ❑ No

If yes, please indicate type of insurance: (check all that apply)

❑ Medicaid ❑ Private Insurance ❑ Medicaid Pending ❑ Public Health Insurance
❑ Medicare Only ❑ VA Program ❑ Medicare plus Medicaid ❑ Charity Care
❑ Medicare plus other supplemental coverage ❑ Emergency Medicaid

Are prescription drugs covered? ❑ Yes ❑ No

Financial Information

Estimated Monthly Family Expenses	Family Assets
Rent / Mortgage:______________ _____	Checking:______________________
Utilities/Phone:______________________	Savings/CD:_____________________
Child Care: _________________________	Money Market: _________________
Transportation ______________________	Stocks:________________________
Medical Bills/Other Debt:____________	Bonds: ________________________
Food: ____________________________	**TOTAL** ________________________
Other:_____________________________	
TOTAL ____________________________	

TOTAL Monthly Family Income:_________________

Currently Employed ❑ Yes ❑ No Number in household_______________

Income Source (Please check all that apply):

❑ Social Security (retirement) ❑ Alimony ❑ Salary ❑ Sick Leave Pay
❑ Pension ❑ Public Assistance ❑ Short Term Disability
❑ In-Kind (room and board) ❑ Child Support ❑ Family/Friends provide support
❑ SSD (Disability) ❑ Unemployment ❑ SSI ❑ Other—Specify _______________

Please continue to back of form

Basic Financial Assistance: Check All That Apply. Please be aware that our basic grants are not for living expenses such as rent, mortgages, utility payments and food, or medical bills and co-pays for insurance. If you need this assistance one of our social workers may be able to refer you to a local agency that can help.

❑ Transportation ❑ Child Care ❑ Home Care ❑ Pain Medications* ❑ Chemotherapy*
❑ Radiation* ❑ Lymphedema Supplies*
*grants for these items are not available in all locations

Special Assistance for Hurricane Victims: Check All that Apply.
❑ Cancer treatments (chemotherapy, hormonal therapy) ❑ Medical equipent (wheelchairs, prostheses)
❑ Medical co-pays for patients ❑ Supportive care medication ❑ Homecare or childcare
❑ Transportation and Lodging ❑ General living expenses

What Other Cancer*Care* Services are you interested in?
❑ Individual Counseling ❑ Support Groups ❑ Educational Programs ❑ Referral to Resources

Signature____
Relationship to Person Applying for Help: ❑ Other Relative ❑ Spouse ❑ Friend ❑ Caregiver ❑ Self

To Be Completed by your Doctor, Nurse or Social Worker Only:
Medical Information

Date of Diagnosis:______________ Primary Cancer: ________________________________

Stage of Cancer:____________ ❑ New Diagnosis ❑ Recurrence In Active Treatment? ❑ Yes ❑ No

If Yes, please indicate type of treatment (check all that apply):

❑ Chemotherapy ❑ Radiation ❑ Clinical Trial ❑ Surgery ❑ Hormonal ❑ Palliative Care
❑ Bone Marrow/Stem Cell Transplant ❑ Complementary/Alternative

If No, is Post Treatment Follow Up Needed? ❑ Yes ❑ No

If Yes, please indicate type of follow up: ❑ Yearly ❑ Every Six Months ❑ Other ____________________

MD Name: ______________________________Hospital/Clinic:____

Address: ____

City/State/Zip: _______________________ Phone: ______________________Fax:________________________

Signature of person completing this section: ____

Print Name/Title:____

Phone (if different than above):__________________________E-mail address_____________________________

Relationship to Person Applying for Help: ❑ Doctor ❑ Nurse ❑ Social Worker

Thank you. A Cancer*Care* social worker or case manager will review this information and contact the person requesting help. Funds are limited and based on availability. **Please fax this form to (212) 712-8495 or mail immediately.** All information is strictly confidential and is for Cancer*Care* use only.

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