21st Century c.a.r.e.
A Foundation for Cancer Assistance, Research & Education
Fighting cancer together with 21st Century Oncology, one patient at a time

Application for Head & Neck Cancer Financial Assistance

Instructions: If you have Head & Neck cancer and need financial assistance, please complete this application and return it to us with the requested supporting documents by mail, fax, or e-mail.

NOTE: Application should be completed in black ink
Applications will be accepted from Head & Neck cancer patients in Southwest Florida.

2234 Colonial Boulevard
Fort Myers, FL 33907
Fax: (239) 938-9399
e-mail: info@21stcenturycare.org

If you have any questions or need assistance completing this application, please call us at (239) 936-3756.

Last Name: _____ First Name: _____ DOB: _____ SS:_____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Alternate phone: _____ E-mail address: _____

☐ Male ☐ Female

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

☐ Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Hispanic ☐ Other ☐ Do not wish to answer

Financial assistance is requested for:

☐ Co-pay for Treatment (please specify amount requested) $_____

☐ Nutritional Supplements (please specify) _____

☐ Transportation ☐ Food

☐ Compression Garment ☐ Trismus Device ☐ Dietician Consultation

☐ Other _____

Total approximate worth of your assets: $_____

House $_____ Car $_____ Savings $_____ Checking $_____ CDs/IRAs/etc. $_____

Other $_____

Attach: ☐ Proof of social security number required ☐ 1st page of my tax return (1040, 1040A, 1040EZ) ☐ I do not file a tax return

☐ Wage or social security/disability statements

All information requested must be included or the application will not be considered

Date of Head & Neck cancer diagnosis: _____

Is the patient in need of financial assistance (required)? ☐ Yes ☐ No

Personnel Name: _____

Hospital/Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Office contact name: _____ Phone: _____

Patient signature

By signing below I authorize 21st Century C.A.R.E. to obtain and discuss information related to this application with my physician and other care providers. I certify that the above statements are true. Payment is dependent on availability of funds. Funds are not always available each month. All information related to this application will be kept strictly confidential and will not be shared with outside persons or agencies. Assistance will be awarded without regard to race, national origin, gender, or sexual orientation and may be suspended at any time due to unavailability of funds. Verification of information provided may be required.

_____ _____

Signature Date signed

---------- For internal use only ----------

Financial assistance committee review: ☐ Approved ☐ Not approved

Date approved: ____/____/____ By: _____

Date approved: ____/____/____ _____

Date approved: ____/____/____ _____

Amount approved: $_____ _____

Office contacted: ___/___/___

Diagnosis verified: ☐ Yes ☐ No

Explain:

Outcome/comments: