Application for Financial Assistance

Instructions: If you have 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 cancer patients that receive treatment in the following states only:
AL, AZ, CA, FL, IN, KY, MA, MD, MI, NC, NJ, NV, NY, RI, SC, WA & WV

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: _____

If the patient is under 18 years old, please provide the name of his/her parent or guardian:

Last Name: _____ First Name: _____

☐ Male ☐ Female

☐ Employed ☐ Disabled ☐ Retired ☐ Student

☐ Unemployed

☐ Caucasian ☐ Asian ☐ Hispanic

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

Financial assistance is requested for:

☐ Transportation ☐ Child care ☐ Food
☐ Respite care ☐ Temporary housing ☐ Other: _____
☐ Medical supplies/equipment ☐ Cancer screening

Note: We do not provide financial assistance for prescription medications, co-pays, deductibles, treatment expenses, mortgage/rent, utilities or other household expenses.

Amount requested: $_____ (If you do not have an exact amount, provide estimate)

Total approximate worth of your assets: $_____

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

Other $_____

Attach: ☐ Proof of social security number (Required) ☐ 1st page of 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

Diagnosis: _____ Date of diagnosis: _____

Physician Name: _____

Hospital/Clinic: _____

Address: _____

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

Office contact name: _____ Phone: _____

Patient/Parent 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 anytime due to unavailability of funds. Verification of information provided will be required. I hereby attest that I have been diagnosed with cancer within 6 months or I am in need of cancer screening and I am experiencing financial hardship. I understand that I may re-apply one time, after one year from the date of this application if a new cancer is diagnosed.

_____ _____
Signature Date signed

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

Financial assistance committee review: ☐ Approved ☐ Not approved

Date approved: ____/____/____ By: _____

Date approved: ____/____/____ _____

Date approved: ____/____/____ _____

Amount approved: $_____ _____

Physician's office contacted: ____/____/____ Contact Name: _____

Diagnosis verified: ☐ Yes ☐ No

Explain:

Outcome/comments: