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 ☐ Employed ☐ Unemployed ☐ Caucasian ☐ Black/African American

☐ Female ☐ Disabled ☐ Retired ☐ Asian ☐ Native American

☐ Student ☐ 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: