



# 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. The patient is to fill out and sign application before submitting to the Physician for signature.

2234 Colonial Boulevard  
Fort Myers, FL 33907  
Fax: (239) 938-9399

e-mail: [info@21stcenturycare.org](mailto:info@21stcenturycare.org)

If you have any questions or need assistance completing this application, please call us at (239) 938-9301.

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

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: \_\_\_\_\_

- |                                 |                                   |                                     |                                    |   |
|---------------------------------|-----------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Male   | <input type="checkbox"/> Employed | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Black/African American                               |
| <input type="checkbox"/> Female | <input type="checkbox"/> Disabled | <input type="checkbox"/> Retired    | <input type="checkbox"/> Asian     | <input type="checkbox"/> Native American                                      |
|                                 | <input type="checkbox"/> Student  |                                     | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Other <input type="checkbox"/> Do not wish to answer |

Financial assistance is requested for:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Transportation             | <input type="checkbox"/> Child care during treatment | <input type="checkbox"/> Education or support meetings |
| <input type="checkbox"/> Respite care               | <input type="checkbox"/> Temporary housing           | <input type="checkbox"/> Food during treatment period  |
| <input type="checkbox"/> Medical supplies/equipment | <input type="checkbox"/> Cancer screening            | <input type="checkbox"/> Other: _____                  |

Have you applied for assistance from other sources?  Yes  No

If you answered yes to this question, provide organization, amount of funds received or requested (use separate sheet if necessary)

\_\_\_\_\_

**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)

Sources of net income in household (alimony, child support or separate maintenance income need not be revealed. Use separate sheet if necessary). Amounts must be shown. You must submit a legible and clear copy of the 1<sup>st</sup> page of your most recent tax return showing adjusted gross income and a copy of all wage statements from the previous month.

\_\_\_\_\_

\_\_\_\_\_

Total approximate worth of your assets: \_\_\_\_\_

House \_\_\_\_\_ Car \_\_\_\_\_ Savings \_\_\_\_\_ Checking \_\_\_\_\_ CDs/IRAs/etc. \_\_\_\_\_

(Use separate sheet if necessary)

Number of people living in your household that can be claimed as dependents on your tax return: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Do you have health insurance (including Medicare/Medicaid)?  Yes  No

Attach:  Copy of social security card (Required)  1<sup>st</sup> page of tax return  Wage statements

**Patient/Parent signature**

By signing below I authorize 21<sup>st</sup> 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. Grants 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 may be required.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date signed

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

----- This section to be completed by the patient's doctor -----

Patient's diagnosis: _____		Date of diagnosis: _____	
Is the patient in active cancer treatment, within 6 months of a diagnosis of cancer, within 6 months of completing treatment, in need of cancer screening and in need of financial assistance (Required) ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Name: _____			
Hospital/Clinic: _____			
Address: _____			
City: _____		State: _____	Phone: _____
Comments:			
Office contact name: _____		Phone: _____	
Physician signature: _____ (Required)		Date: _____	

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

Financial assistance committee review:		<input type="checkbox"/> Approved <input type="checkbox"/> Not approved	
Date approved: ___/___/___	By: _____		
Date approved: ___/___/___	_____		
Date approved: ___/___/___	_____		
Amount approved: \$ _____	_____		
Outcome/comments:			