



The Hope Chest  
for Women  
Financial Aid Application

### Patient Information

**Please complete all information and print legibly.**

First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security/Green Card #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Diagnosis (Type of cancer): \_\_\_\_\_ Physician (Oncologist): \_\_\_\_\_

When were you diagnosed? \_\_\_\_\_ What is your current treatment? \_\_\_\_\_

### Insurance Information

*(Please complete if you have insurance coverage)*

Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_

Do you have a drug plan?  Yes  No Type of plan: \_\_\_\_\_

Do you receive state assistance?  Yes  No

Do you receive assistance from other sources?  Yes  No

If yes, please list:

### Financial Information

List all sources of gross monthly income. Attach copies of proof of income (1040, 1040A, 1040EZ, 1099, SSA1099, or 4506T) for you and all dependent persons in the household.

Total Monthly Net Family Income

Total Family Liquid Assets

Average Monthly Out-of-Pocket Medical Expenses

\$ \_\_\_\_\_  
Include salary, pension, SS, disability,  
earnings from dividend,  
rental property, etc.

\$ \_\_\_\_\_  
Include checking, savings,  
money market accounts;  
CDs, IRAs, etc.

\$ \_\_\_\_\_  
Prescriptions, doctor visits, labs,  
hospital, etc.

Number of people in the household: \_\_\_\_\_

Current employment status: \_\_\_\_\_

## Funding Request

What kind of funding do you need?

Please be specific: Physician payments, medical expenses, prescriptions, etc.

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Who referred you to The Hope Chest? \_\_\_\_\_ Phone: \_\_\_\_\_

## Information Release Statement

I attest to the above information being correct and complete to the best of my knowledge. By my signature, I authorize the release of the above information to The Hope Chest and I authorize The Hope Chest to use the above information to contact my insurer, other potential funding sources, social workers, or patient advocacy organizations on my behalf to determine my eligibility for alternative financial support through The Hope Chest.

I also authorize The Hope Chest to contact my insurer, health care provider, or dispensing agent, and I authorize aforementioned entities to disclose information to The Hope Chest, relative to my medical condition, treatment or drug therapy as requested by The Hope Chest. Disclosure of this information may include, but is not limited to, the electronic transmission of information. The Hope Chest agrees to request only that information needed to process this application, to renew it, and to provide continued assistance during my participation in the program. The Hope Chest also agrees not to disclose any information obtained from these sources to any third party except as authorized by me or as required by applicable law.

This authorization shall continue in effect until final decisions have been made regarding this application. I also understand that submitting this application does not guarantee financial or other support from The Hope Chest.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Required Documents**

Please attach applicable information to this form including:

Proof of income

Pathology report

Copy of bill(s) to be considered for payment

If you have questions, please call (828) 418-1344.