ARIZONA ONCOLOGY FOUNDATION

Health, Healing, Survivorship!

FINANCIAL ASSISTANCE FOR COMPLEMENTARY SERVICES APPLICATION FORM

PHYSICIAN SECTION

Patient Name:		**Date:**
Patient Address:		
Patient Home Phone:	**Patient Cell Phone:**	**Type of Cancer (No Codes Please):**
Referring Physcian Name:	**Physician Location:**	**Physician Office Phone:**
Please list the type of therapy you are interested in receiving:		

☐ **I certify that this patient meets criteria for financial assistance**

Referring Physician Signature:_____
(**REQUIRED**)

DEMOGRAPHIC INFORMATION (to be filled out by Patient)

The information requested on this form is used by Arizona Oncology Foundation for statistical purposes only. It helps provide information to donors & funding organizations and to evaluate our programs & services. Names are never disclosed. Your help is appreciated.

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Widowed

Age Range: ☐ 18-29 ☐ 30-60 ☐ 60 and Above

Racial/Ethnic Background:

☐ African American ☐ Caucasian White ☐ Multi-Racial
☐ Asian/Pacific Islander ☐ Latino/Hispanic ☐ Native American/American Indian
☐ Other (Please Specify)_____

Income:

☐ Less than $12,000 ☐ $12,001 - $24,000 ☐ $24,001 - $35,000
☐ $35,001 - $40,000 ☐ $40,001 and above

Residency: City_____ County_____ Zip Code_____

Number in household _____ **Number under the age of 18 _____**

Have you ever received AO Foundation services? ☐ Yes ☐ No / ☐ Gas Cards ☐ Therapeutic Vouchers

PLEASE SUBMIT TO: ARIZONA ONCOLOGY FOUNDATION