Hope Has A Name Fund Inc.

Patient Assistance Financial Questionnaire

Please fill out all information requested. If there are empty spaces it will delay processing.

Our goal is to provide applicants who qualify a subsidy to cover some or all of the cost of at least one therapy per week. This application will be eligible for potential awards of up to $35 per treatment with a maximum of 24 treatments (a $840 value).

Name:_________________________________
Address: ______________________________
City: _____________State: ________________Zip Code: _______________
DOB: __________Phone_____________ EMail: ________________________

Marital Status: Single___Married___Divorced___Widowed______
How many family members in your household? Adults___Children____
How long at present address:____Own___Rent___Other___
Are you? Employed___Unemployed___Retired___Disabled___

Employer Information:
Employer: ____________________________ Work Phone:____________
Address: ____
Your Position: ________________# of months/years employed: __________
Income Annual: _______Monthly:________Bi-Weekly______
Hourly: _______If hourly # hours worked per week:_________
Supervisor: ___________________Work Phone: __________________

Income verification may be required. Verification may include proof of monthly or yearly income i.e.....: paystubs, SSI Statements, check stubs, W-2, most recent tax return or other forms.

Date of Diagnosis: ___________Diagnosis: _________________
In treatment? Yes_____ No_____ If not when was treatment completed? ________
If yes what type of treatment are you receiving?
____

Primary Cancer Physician: ______________________Phone:___________________
If Physician is with an institution or group what is the name?____________________________
Address: _______________________________________

How did you hear about Hope Has A Name Fund? (Who referred you?) _________________

Please tell us the benefits you feel you have received from healing therapies in the past or how this program will help now:
____
____
____
____
____

May we share this information for purposes of documenting the beneficial outcomes these therapies have for Cancer patients?_____________ May we use your name? ________________

Confidential Questionnaire

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Section I- Monthly Income Sources

Patient Income: ____________
Self Employment: ___________
Social Security Income: ___________
Alimony/Child Support: __________________
Pension Income: _______________________

Spouse Income:_____________
Welfare Income:_____________
Workman's Comp/Unemployment:__________

Total Family Income: (gross)________________

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Financial Assets (average balances)

Cash Available: __________
Stocks/Bonds: ___________
Home Value: _________

Savings/Checking Balance: ________________
Other Investments: ____________________
Mortgage remaining: __________________

Is this your only real estate? _____
If not itemize properties values and mortgages:

1) Value:________Mortgage:_________Rental Income:____________
2) Value:________Mortgage:_________Rental Income:____________

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Section II: Living Expenses (monthly):

Mortgage/Rent:__________ **Property taxes**:__________(may be included in mortgage payment)

Groceries: ______________ **Insurance** (auto, health, home, life etc.)_____________

Excess Medical expenses: ______________________(not paid by insurance)

Utilities: ______________ (gas, electric, water, garbage) **Phone:**___________

Cable: ___________ **Automobile:**___________(inc. gas, repairs etc.)

Total Monthly Income ***(all of Section I)***: ___________________

MINUS

Total Monthly Expenses: ***(all of Section II)***: _________________

Monthly Balance (+ or -): _____________

If you have additional information we want us to consider just write a note and send with application

I hereby state that the information on these forms is true and complete. I authorize any required income verification needed including a Credit Bureau Report of IRS release of tax return. I understand that if this information is found to be false I will be remove from the program and liable for full payment of any services received.

Signatures Required below:

Applicant:__________________ Spouse: ________________ Date: ____________