WOMEN'S ONCOLOGY FOUNDATION OF GREATER CHATTANOOGA

APPLICATION FOR FINANCIAL ASSISTANCE

TELL US ABOUT YOURSELF

Is this your first application for assistance? Yes ☐ No ☐

First Name: _____ Last Name: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home phone #: _____ Cell phone #: _____

Marital Status: _____ # of Dependents and ages: _____

Number of people living at this address (including non-dependents and dependents): _____

Relation to you: _____

HELP US UNDERSTAND YOUR DIAGNOSIS

Type of Gyn Cancer: Primary Peritoneal ☐ Ovarian ☐ Uterine ☐ Cervical ☐

Vulva ☐ Vaginal ☐

Date Diagnosed with cancer: _____

Stage: I ☐ 2 ☐ 3 ☐ 4 ☐

Treatment(s) received, current, or required	Date (from-to)	Name of facility

If you need more room please use a blank sheet of paper and attach with your application.

Are you still receiving chemotherapy and/or radiation? Yes ☐ No ☐

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YOUR MEDICAL TEAM

Family Doctor: _____ Phone Number: _____

Gyn Oncologist: _____ Phone Number: _____

Radiation Oncologist: _____ Phone Number: _____

The confirmation of your diagnosis and the information related to the treatments received or currently received or to follow must be provided by your medical team on a letterhead. This document must be sent along with the application.

PLEASE HELP US UNDERSTAND YOUR FINANCIAL SITUATION

Are you receiving financial aid from the government or other institutions? Yes ☐ No ☐
If YES, please indicate the origin: _____ and amount $: _____

Are you presently working? YES ☐ Current position: _____

Full time ☐ Part time ☐

NO ☐ If NO, state the last day of work: _____

Do you have a Cancer Insurance Policy? Yes ☐ No ☐ If YES please include in Income.

Household Gross Monthly Income	Origin	Yourself	Spouse/Partner	Child(ren)	Other Person
Salary		$	$	$	$
Social Aid		$	$	$	$
Child Support		$	$	$	$
Pension		$	$	$	$
Other (specify)		$	$	$	$
Other (specify)		$	$	$	$
Total per person		$	$	$	$
Total revenue					$

Your monthly expenses:	Monthly mortgage/rent	$
	Groceries/Food	$
	Cable/phone/internet	$
	Utilities	$
	Car payment/loan	$
	Insurance	$
	Other (specify)	$
	Other (specify)	$

Total Gross Revenue $_____Total Expenses $_____ Difference $ _____

WOMEN'S ONCOLOGY FOUNDATION OF GREATER CHATTANOOGA

PLEASE TELL US HOW THE "WOMENS ONCOLOGY FOUNDATION OF GREATER CHATTANOOGA" CAN HELP?

Our goal is to financially assist you so that you can focus on your treatment/recovery

_____

_____

_____

_____

_____

_____

Note: Your request MUST include at least one expense related to your medical treatment. (Alcohol, soda, magazines, lottery tickets, pet food and products, and plastic bags are not eligible. Please make sure that you deduct their cost from the requested amount.)

Your Gyn Cancer treatment related expenses

Type of expense (please indicate)	Amount	Receipts to include	Included
Medication (for applicant only)	$	Original Pharmacy Receipts (patient's name)	
Other Medical expense(s) (please indicate) for applicant only	$	Original Receipts	
Prosthetics, wigs	$	Original Receipts	
Medical Travel expenses (gas, bus, taxi, etc.) (max allowance is $300)	$	Original Receipts **and** copy of appointment-visit schedule	
Parking, accommodation and meal expenses during treatment (please indicate)	$	Original Receipts **and** copy of appointment-visit schedule	

Your other expenses

Mortgage or lease (max allowance is $700) Do you have mortgage Insurance? Y/N	$	Copy of current lease or mortgage statement of account	
Groceries (max allowance is $400)	$	Original Receipts	
Utilities – expenses related to the housing (max allowance is $300)	$	Copy of invoice(s)	
Other (please indicate	$	Original Receipts or copy of the invoice	
Other (please indicate	$	Original Receipts or copy of the invoice	
Other (please indicate	$	Original Receipts or copy of the invoice	

Total amount requested: $ _____

Note: The maximum amount payable per request is $1,000. Excess amounts WILL NOT BE carried over for a future request (some exceptions however can be made). **ORIGINAL RECEIPTS MUST BE INCLUDED and must be dated within 12 months of your application date.** If you do not submit a treatment related expense, this request could be denied.

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AUTOGRAPH

(Applicant must sign and authorize release to confidential information)

☐ *I have read and understood the guidelines listed in the document "criteria" . I certify that the above information is accurate. I also understand that this information and the documents included are to be used by the Women's Oncology Foundation for the sole purpose of assisting me financially.*

_____ _____

Signature of Applicant Date of application

Note: any false, fraudulent or misrepresented information will result in the denial of an application. If an application is denied due to the fore mentioned no further applications will be considered for the remainder of the calendar year.

PLEASE HELP US TO HELP OTHERS

How did you find out about our organization? _____

Other comments or suggestions? _____

_____

_____

Women's Oncology Foundation of Greater Chattanooga
P.O. Box 368
Signal Mountain, TN 37377

Email: wofogc@gmail.com

WOMEN'S ONCOLOGY FOUNDATION OF GREATER CHATTANOOGA

Please Read Carefully and Fully

Document Checklist for Application

We understand that life is difficult and we would like to make this application process as easy as possible for applicants. Therefore, it is important to note that the documentation requested below is **MANDATORY** in order for a request to be considered. It is important to note that an application is considered to be incomplete and will not be submitted to the Approval Committee if ALL pertinent documentation is not included.

An incomplete application will be returned to applicant for re-submittal

In order to establish financial need, applicants **MUST:**

- ✓ Provide current income tax
- ✓ Receipts **MUST** be provided for amounts claimed through the fund (originals are required, must be organized and NOT highlighted) .
- ✓ Applications requesting assistance for rent or mortgage **MUST** include documentation supporting the amount they are requesting.
- ✓ Each application must include an item directly related to gyn cancer diagnosis and/or treatment.

Kindly note that if the requested documentation is not included, it will only delay any financial assistance that could possibly be provided.

THE FOLLOWING MUST BE INLCUDED WITH YOUR APPLICATION:

Documents to include (Use this table as a check-list, once the document is included, check the appropriate box)	**For 1st request**	**For additional request the same calendar year**	**For additional request the next calendar year**
Official document from your health center confirming diagnosis, treatments received, current and to follow		**N/A**	
Copy of your current tax return, include spouse/partner if applicable		**N/A**	
Proof of other funding received/copy of income statement		**N/A**	
Original receipts (medications, groceries, transportation, parking, accommodation, meals)			
Copy of utilities invoice			
Copy of current lease or mortgage statement (document showing the paid amount)		**N/A**	
Copy of your long term disability coverage if applicable		**N/A**	
Application form signed by the applicant			

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