East Texas CANCER ALLIANCE of HOPE

APPLICATION

TO BE FILLED BY A HEALTHCARE PROFESSIONAL

PATIENT FULL NAME: _____ DATE OF BIRTH ____/____/____

ADDRESS: _____ PHONE _____-_____-_____

WHAT ARE THE CIRCUMSTANCES CAUSING THIS FAMILY TO SEEK ASSISTANCE?

_____

_____

_____

_____

_____

PLEASE PICK THE CATEGORY THAT BEST DESCRIBES HOW THIS REQUEST WILL BENEFIT THE CLIENT/PATIENT? PLEASE CHECK ALL THAT APPLY.

- ◯ UTILITY BILLS: GAS, ELECTRIC, WATER
- ◯ GAS VOUCHERS
- ◯ NUTRITIONAL ASSISTANCE
- ◯ DURABLE MEDICAL EQUIPMENT
- ◯ INSURANCE CO-PAYMENTS
- ◯ MEDICATION NOT COVERED BY INSURANCE
- ◯ RESTAURANT VOUCHERS
- ◯ PARTIAL RENT/MORTGAGE PAYMENT
- ◯ LODGING EXPENSES

PLEASE LIST WHO THE CHECK SHOULD BE MADE PAYABLE TO

****NOTE** NO PAYMENTS ARE MADE DIRECTLY TO CLIENTS**

PAYABLE TO: _____ ATTENTION TO: _____

ADDRESS: _____ PHONE _____-_____-_____

ACCOUNT NUMBER: _____ AMOUNT REQUESTED $_____

I HAVE REVIEWED THIS APPLICATION AND I AGREE WITH THE FUNDING NEED.

REFERRING HEALTHCARE PROFESSIONAL NAME _____ DATE ____/____/____

ORGANIZATION _____ PHONE _____-_____-_____

PLEASE EMAIL THIS FORM TO INFO@ETXCANCERALLIANCEOFHOPE.ORG
or **MAIL** TO P.O. BOX 151114 LUFKIN, TX 75915

FOUNDATION USE ONLY:

PRINT NAME _____ SIGNATURE _____

CHECK NUMBER _____ CHECK AMOUNT $_____ CHECK DATE ____/____/____