GIFT OF HOPE

Application

Please review the criteria for the Gift of Hope's financial assistance program before applying. The application must be filled out and submitted by an appropriate referral source, a social worker, oncology nurse, patient navigator or case manager – not the patient. Please print clearly

Patient Contact information

First Name: _____

Address: _____

City, State, Zip: _____ County: _____

Home Phone #: _____ Email: _____

Patient Signature: _____ Application Date: _____

Patient Medical Information

Patient Diagnosis Date: _____ Patient Diagnosis: _____

Please detail what specific treatment the patient is currently receiving: _____

_____

Date treatment began_____ Date treatment is expected to end_____

Referral Information (social worker, oncology nurse, patient navigator, case manager must fill out)

First Name_____ Last Name _____

Position/ Title _____ Facility _____

Address _____

City, State, Zip, _____

Telephone #_____ Email _____

As the medical referral, my signature attests to the accuracy of the medical information about this patient.

Referral Signature _____ Date_____

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Biographical information

Name: _____ Date of birth: _____

Street Address: _____

City, State, Zip: _____County: _____

Home Phone: _____Work#:_____Cell#:_____

How best to reach you? Home Work Cell Best time? _____

Secondary Contact and Phone Number: _____

Marital Status: Single Married Separated Divorced Widowed

Of Children: ____ Ages: ___Do you live alone? ____ #of adults in home? _____

Language(s) spoken: English Spanish Asian Other

Please tell us your reasons for applying to the Gift of Hope: _____

_____

How did you hear about the Gift of Hope? _____

_____

Name of person who referred you: _____

Referring person's telephone #: _____

What specific assistance are you seeking? _____

_____

Is there anything else you would like to tell us about yourself and your situation?

_____

Financial assistance from The Gift of Hope is for the duration of qualifying treatments only and shall not exceed a period of 4 mouths.

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Monthly household income _____

Do you have a checking account _____ Submit copy of last statement

Do you have a savings account _____ Submit copy of last statement

Credit cards	Company Name	Balance Owed

Please attach a copy of the following;

Last tax return

Copy of photo ID

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Medical Information

Current Diagnosis

Date Diagnosed: _____Stage: _____Type:_____

Qualified Treatments: Date of / date began Estimated ending date Number of treatments

Chemotherapy:

Radiation Therapy:

Are you being treated for a recurrence?

Name Location Phone #

Surgeon: _____

_____

Oncologist:_____

Oncology Nurse: _____

Radiation Oncologist: _____

Social Worker/Case Manager: _____

Other: _____

I understand that THE GIFT OF HOPE provides free services that all awards are made at the sole discretion of THE GIFT OF HOPE. The information provided in this application is true. I release THE GIFT OF HOPE of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize THE GIFT OF HOPE to release any information including my name, address, and type of assistance provided to any other social service agency at its discretion. I also authorize the release of any medical information and documentation required by THE GIFT OF HOPE for verifying this application and I agree to sign any additional authorizations that may be required. The Gift of Hope terminates all financial assistance on the completion of chemotherapy and/or radiation.

Applicant's Signature: _____ **Date** _____

Print Name: _____