***Please Print***

# HEARTS FOR HOPE
## CANCER FOUNDATION

**Financial Assistance Application**

Date_____

**PATIENT INFORMATION**

LAST NAME_____ FIRST NAME, M.I._____

SSN#_____ DOB_____ U.S. CITIZEN(Y/N)_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

*EMPLOYER INFO/SCHOOL IF STUDENT/OR UNEMPLOYED*

EMPLOYER/SCHOOL_____ ADDRESS_____

CITY _____ STATE_____ ZIP _____

PHONE #_____

RELATIONSHIP TO PATIENT (SELF/SPOUSE/PARENT, GUARDIAN/OTHER)_____

**HOUSEHOLD INFORMATION**

NO# IN HOUSEHOLD _____ HOW MANY IN HOSEHOLD ARE EMPLOYED_____

IS ANYONE IN HOUSEHOLD RECEIVING UNEMPLOYMENT OR SSI? (Y/N)_____

**IF PATIENT IS A DEPENDENT PLEASE FILL OUT INFORMATION OF PARENTS/GUARDIANS WHO ARE EMPLOYEED*

*HOUSEHOLD MEMBER #A*

LAST NAME_____ FIRST NAME, M.I._____

SSN#_____ DOB_____ U.S. CITIZEN (Y/N)_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

*EMPLOYER INFO*

EMPLOYER_____ ADDRESS_____

CITY _____ STATE_____ ZIP _____

PHONE #_____ (PART/FULL TIME)_____

*HOUSEHOLD MEMBER #B*

LAST NAME_____ FIRST NAME, M.I._____

SSN#_____ DOB_____ U.S. CITIZEN (Y/N)_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

*EMPLOYER INFO*

EMPLOYER_____ ADDRESS_____

CITY _____ STATE_____ ZIP _____

PHONE #_____ (PART/FULLTIME)_____

**OTHER HOUSEHOLD OCCUPANTS**

NAME_____ D.O.B._____

NAME_____ D.O.B._____

NAME_____ D.O.B._____

NAME_____ D.O.B._____

NAME_____ D.O.B._____

***PLEASE TAKE THE NEXT FEW LINES TO COMPLETE ADDITIONAL INFORMATION WE WILL NEED. FOR EXAMPLE SECOND JOB INFORMATION, PARENT THAT DOES NOT LIVE IN HOUSEHOLD BUT PATIENT GETS INCOME/CHILD SUPPORT FROM.

_____

_____

_____

_____

_____

_____

_____

_____

**Questionnaire**

Is Patient CURENTLY being treated for some type of cancer?_____

What type of cancer is patient being treated for?_____

Date of last treatment_____ Location_____

Has patient received assistance from another organization? _____

Has an application been put in already with us or another organization? _____

IF YES to previous 2 questionsWhom?_____

Is the patient eligible or receiving for a state medical assistance program? _____

Has patient or heads of household been convicted of a felony? If yes please give details_____

_____

**Patient Medical Information**

Primary Doctor _____

ADDRESS_____

CITY _____ STATE_____ ZIP _____

PHONE #_____ May we contact (Y/N)_____

Does the patient receive Medicaid or Medicare? _____

Does the patient have health insurance? (Y/N)_____ If Yes please provide the following information

Health Insurance Name_____

Subscribers Name_____

Patients Identification No#_____

Group No#_____

Group Employer Name_____

Effective Date_____

Health Insurance Telephone No#_____

Other Doctors or Hospitals who have treated the patient _____

_____

_____

_____

_____

Is patient taking chemotherapy? _____If yes, date of last treatment_____

Has the cancer been deemed terminal or untreatable?_____

Medications patient is taking_____

_____

**Personal References whom we can contact**

Name_____ Years Known_____

Phone_____ Relationship_____

Name_____ Years Known_____

Phone_____ Relationship_____

**********READ BEFORE SIGNING**********

Patient, Parent Guardian, or Person with Power of Attorney

I certify that all information provided on this application is TRUE and complete to the best of my knowledge and that I have withheld nothing that, if disclosed would impact the outcome of this application.

I authorize Patients doctors, hospitals, or any other person listed on application any information regarding patient and families record/background. I agree that this company will not be held liable in anyway if a financial offer is not extended. The application is automatically withdrawn if there is any false statements, or omissions that would change outcome of application. If financial assistance is granted. I will comply will all rules and regulations that are set by the Hearts for Hope Cancer Foundation.

I understand that financial assistance is "at will" which means that either I or Hearts for Hope Cancer Foundation can terminate the relationship at any time, with or without prior notice and for any reason not prohibited by statue. I hereby acknowledge that I have read and understand the above statements.

If your application is approved we may use your image, likeness, story, name, or any other relevance to your situation on our webpage, or other advertising such as ads, brochures, TV, Radio, paper, etc. By signing this form you are giving your consent for your approval.

Signature_____

Print Name_____

Date_____

Please send the above application along with:

-2 most recent pay stubs

-2 months bank statements and last quarter's retirement statements

-At least a 2 paragraph typed or hand written letter explaining your families' situation and how cancer has affected your families' life.

| Mail: | OR | Fax: | OR | Email: |
|---|---|---|---|---|
| Hearts for Hope Cancer Foundation | | 1 (240) 993 3760 | | info@h4hcf.org |
| 15720 John J. Delaney Drive | | | | |
| Suite 300 | | | | |
| Charlotte, NC 28277 | | | | |

Our policy is to provide to all qualified persons without regard to race, creed, color, sex, age, national origin, physical or mental disability, or veteran status. This application is for financial assistance to hose suffering with Cancer in the United States. All applications will be thoroughly checked by our staff.

# Cash Flow

## INCOME (Annual)

| | | |
|---|---|---|
| Salary | $ _____ | $ _____ |
| Bonus | _____ | _____ |
| Commissions | _____ | _____ |
| **Total** | $ _____ | $ _____ |
| **Total Combined Incomes** | | $ _____ |

## DISBURSEMENTS (Monthly)

| Expenses | |
|---|---|
| Mortgage/ Rent/ Utilities | $ _____ |
| Car / Truck Payments | _____ |
| Gas / Maintenance | _____ |
| Food / Dining Out | _____ |
| Entertainment | _____ |
| Cell Phone(s) | _____ |
| Childcare | _____ |
| Student Loans | _____ |
| Personal Care | _____ |
| Dry Cleaning | _____ |
| Charitable Contributions | _____ |
| Credit Cards | _____ |
| Membership / Dues | _____ |
| Other _____ | _____ |
| **Total Expenses** | $ _____ |

| Insurance | |
|---|---|
| Homeowners | _____ |
| Auto | _____ |
| Life | _____ |
| Disability | _____ |
| Long-term Care | _____ |
| Other _____ | _____ |
| **Total Insurance** | $ _____ |

| Savings | |
|---|---|
| Savings / Money Market | _____ |
| 401(k) | _____ |
| Brokerage Account | _____ |
| IRAs (Roth, Traditional, etc) | _____ |
| College Savings | _____ |
| Other _____ | _____ |
| **Total Savings** | $ _____ |

| Taxes | |
|---|---|
| Federal | _____ |
| State | _____ |
| OASDI / Medicare | _____ |
| **Total Taxes** | $ _____ |

**Surplus / Shortage** $ _____

# Savings Plans / Retirement Plans / Liabilities

## Savings Plans

| Account Name | Owner | Current Value | Monthly Savings | Rate of Return | Assigned to Goal: *Death* | *Emerg.* | *Fin. Indep.* |
|---|---|---|---|---|---|---|---|
| Bank Account | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |
| Money Market | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |
| CD's | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |
| Mutual Fund | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |
| Stocks / Bonds | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |
| Real Estate (not home) | A / B | $_____ | $_____ | ___% | ☐ | ☐ | ☐ |

## Retirement Plans (401(k), IRA (Roth/ Traditional), Annuities, SEP, KEOGH)

| Account Name | Owner | Amount | Monthly Savings | Company Match | Rate of Return | Available at Death |
|---|---|---|---|---|---|---|
| _____ | A / B | $_____ | $_____ | $_____ | ___% | ☐ |
| _____ | A / B | $_____ | $_____ | $_____ | ___% | ☐ |
| _____ | A / B | $_____ | $_____ | $_____ | ___% | ☐ |
| _____ | A / B | $_____ | $_____ | $_____ | ___% | ☐ |
| _____ | A / B | $_____ | $_____ | $_____ | ___% | ☐ |

## Other Sources of Income (Alimony, Child Support, Rental Income, Pension Plans. )

| Name | Description | Amount | Monthly Amount | | Lump Sum | Today's Value | | Future Value | Begins at Age | Ends at Age | Annual Increase | Is income available to survivors? Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| _____ | _____ | $_____ | ☐ | or | ☐ | ☐ | or | ☐ | ____ | ____ | ___% | ☐ | ☐ |
| _____ | _____ | $_____ | ☐ | or | ☐ | ☐ | or | ☐ | ____ | ____ | ___% | ☐ | ☐ |

## Liabilities

| Name | Value | Amount Owed | Monthly Payment | Interest Rate | Final Payment Date |
|---|---|---|---|---|---|
| Primary Residence | $_____ | $_____ | $_____ | ____% | _____ |
| Credit Cards | $_____ | $_____ | $_____ | ____% | _____ |
| Student Loan | $_____ | $_____ | $_____ | ____% | _____ |
| Auto Loan | $_____ | $_____ | $_____ | ____% | _____ |
| _____ | $_____ | $_____ | $_____ | ____% | _____ |
| _____ | $_____ | $_____ | $_____ | ____% | _____ |