SAS Cervical Cancer Foundation

Confidential Application for Financial Assistance

- The SAS Cervical Cancer Foundation is a non-profit organization who provides assistance only to individuals with cervical cancer.
- You will be notified by mail within 60 days as to whether or not your application has been approved.
- All applicants may re-apply after 1 year.
- Funds are limited and based upon availability and applicant's need, and are in no way based upon race, creed, or ethnicity.
- "Assistance" may be in the form of a monetary payment to the applicant, a payment directly to a debtor, a gift certificate for staple items, or the like. Forms of assistance will be decided on a case by case basis by the Financial Aid Review Committee.
- Approval of this request grants a one-time assistance payment and does not necessarily promise future financial assistance.
- All information is held in the strictest confidence and is used only by the SAS Cervical Cancer Foundation for the purpose of reviewing financial assistance needs.

PLEASE BE SURE TO:

- Answer each question or indicate if an item does not apply to your situation
- Sign and date the application
- Have your doctor, nurse, or social worker complete the Medical Information section
- Provide a phone number where you can be reached to answer any additional questions

Please return this application to:
SAS Cervical Cancer Foundation
Attn: Financial Aid Review Committee
2516 North Richmond St.
Appleton, WI 54911

PERSONAL INFORMATION

Date: _____

Applicant's Full Name:_____

Spouse's Full Name:_____
(If you are legally married, you must indicate your spouse's name here. You may explain separations or other living arrangements in the biography section.)
Address: _____**Age:** _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: Home ( ) _____ **Work:** ( ) _____
Cell: ( ) _____
Referred by: _____

Number of people living in your household: ____**Adults** ____**Children**
Do you rent or own this home? _____

Name & address of your employer _____

_____

Name & address of spouse's employer _____
_____

Type of health insurance: (please circle all that apply)

Private Health Insurance Provider	Medicare plus other supplemental coverage
(i.e. Medical Mutual, Kaiser, etc.)	Federal Breast & Cervical Cancer Treatment Act
Medicaid VA Program	Medicaid Pending Charity Care
Emergency Medicaid	Other _____
Medicare plus Medicaid	None

If private insurance indicate name of insurance company and type of plan:
_____

Are prescription drugs covered? Yes No

Name of primary insured and their relationship to you:_____
_____

Have you previously applied for assistance from our Foundation? Yes No

If yes, please indicate date and outcome of your application

Applicant Name: _____

ASSISTANCE ASSESSMENT

For what purpose are you seeking financial assistance?

Housing Costs Utility Costs Food Costs Transportation Child Care
Home Care Other _____

What other cancer services are you interested in?

Individual Counseling Support Groups Educational Programs/Seminars
Referral to Resources

MEDICAL INFORMATION

To Be Completed ONLY by Applicant's Doctor, Nurse or Licensed Social Worker

Primary Cancer: _____ Date of Diagnosis: _____

Stage of Cancer: _____ Is this a New Diagnosis Recurrence

Are you in active treatment? Yes No

If Yes, please indicate type of treatment: (please check all that apply)

Chemotherapy Radiation Surgery Bone Marrow/Stem Cell Transplant
Palliative Care Clinical Trial Hormonal Complementary/Alternative

If No, will post-treatment follow-up required? Yes No

Please indicate the frequency of post-treatment follow-ups?

Yearly Every Six Months Other _____

Physician's Name: _____ Hospital/Clinic: _____

Address:_____

City/State/Zip: _____ Phone: _____ Fax: _____

Signature of doctor, nurse, or social worker: _____

Print Name/Title: _____

FINANCIAL INFORMATION

Total Household Monthly Gross Income (from all sources from everyone living in your household) $_____

Total Household Liquid Assets (Cash on hand, checking or savings, money market, CD's, stocks) $_____

Total Monthly Expenses (Housing, utilities, childcare, food, transportation, medical bills) $_____

Applicant Name:

_____

BIOGRAPHY

This section is a chance for you to tell your story. Please use the space below and no more than 1 other sheet of paper (if needed) to indicate what your specific circumstances are (duration of your cancer, what immediate needs you have, special work/income limitations, etc.). Also, if the Financial Information section shows that your current income exceeds your expenses, please explain the circumstances.

AGREEMENT AND SIGNATURE

Please read and sign below after you have carefully reviewed your completed application. By signing this application, I confirm that I am solely responsible for the accuracy of all information contained herein. I grant permission to the doctors and medical professionals contained herein to discuss with the SAS Cervical Cancer Foundation any information regarding my cervical cancer treatment, diagnosis, prognosis, etc. I understand that the SAS Cervical Cancer Foundation will use any information obtained solely for the purpose of considering financial assistance and that all of my medical information will be held in strict confidence.

I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release.

_____

Applicant's Signature