911 *4* HNC

Website: www.HeadandNeckCancer911.org

The 911*4*HNC Fund (Help for Head and Neck Cancer Fund) is dedicated to granting financial aid to patients with head and neck cancer. The two priorities of the fund will be to raise money to assist greater numbers of individuals and to raise public awareness of the critical needs of people undergoing treatment for head and neck cancers. Improving the quality of life for those with head and neck cancer is the foremost goal of this endeavor.

Financial Assistance Application for HNC Patients of Metropolitan DC Area Hospitals

________________ **Patient Information PLEASE PRINT ALL INFORMATION – THANK YOU**

First Name:__________________________ Last Name:_____________________________ Date:____________

Address: _____________________________________ City, State, Zip Code:______________________________

Phone Number: Home ( )________________ Work ( )________________ Cell ( )_______________

Email Address:____

☐ Male ☐ Female

Date of Birth:_______________

If patient is a minor (under 18) please provide name of parent/guardian and phone number:
Name: _______________________ ____ Phone number:_______________________

Medical Information **(must be completed by a doctor, nurse or social worker)**

Date of diagnosis:_____________ Primary cancer:_______________________________________Stage: ______

☐ New Diagnosis ☐ Recurrence ☐ In Active Treatment

Please indicate type of treatment(s) received in past 12 months:

☐ Radiation Therapy ☐ Chemotherapy ☐ Surgery ☐ Palliative Care

Health Care Professional Information

Physician Name:_____________________________ Hospital/Clinic:_________________________________

Address:____ City, State, Zip Code:___________________________

Phone:______________________________ Fax:____________________________

911 *4* HNC Financial Assistance Application Applicant:________________________________ DOB:______________

Name and Title of Person Completing this Section (If Not Physician)

Name:________________________________ Title:________________________________

Phone: ( )________________________________ Email: ____

Signature:____________________________________ Date:_______________

Health Insurance Information:

Do you have health insurance: ☐ Yes ☐ No

If so, type(s) of insurance:

☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Medicare plus Medigap ☐ Charity Care ☐ VA

☐ Other Are your prescription drugs covered? ☐ Yes ☐ No

Household Financial Information:

Are you currently employed ? ☐ Yes ☐ No Number of people in your household: ________

Do you have any dependents? ☐ Yes ☐ No If yes, how many: ________

Do you: ☐ own a home ☐ rent

Family Income Sources:

☐ Social Security (retirement) ☐ Salary ☐ Pension ☐ Unemployment

☐ Public Assistance ☐ Short-term Disability ☐ SSDI (Disability)

☐ SSI ☐ Family/Friends provide support ☐ Other – specify _______________________________

Total Annual Household Income**:** **$_________________**

Household Assets:

Checking/Money Market: $_________________ Savings/CDs: $_____________________
IRA/403B/401K $_________________ Stocks & Bonds: $_____________________

911 *4* HNC Financial Assistance Application Applicant:______________________________ DOB:______________

Please provide any additional information, in 100 words or less, about your circumstances that might help us in our decision-making:

____

____

____

____

____

____

Financial Assistance Needs

☐ Prescription medications (Please describe type):____

☐ Transportation

☐ Therapeutic Nutrition Products (e.g. Ensure)

☐ Other (please explain) ____

Amount of Assistance Requested: $______________________ (grants up to $500 determined based on need)

To the best of my knowledge, the information provided above is accurate. I understand that completion of this application does not automatically guarantee granting of funds. Funds are limited and based on availability. All information is strictly confidential and is for the use of the HNC911 Review Board in determining financial eligibility.

Signature:____ **Date:___________________**

Please mail this form to: 911 *4* HNC c/o Cookie Kerxton, 4550 N. Park Ave., Suite 506, Chevy Chase MD 20815

911 *4* HNC will review this information and contact the individual who is requesting financial assistance. Healthcare professional signature required for processing.