

The 9114HNC 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: \_\_\_\_\_

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:

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**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 \$750 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.**