911 *4* HNC Website: https://courageunmasked.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: Cell ( )_____ Work ( )_____

Email Address:_____ Date of Birth:_____ ☐ Male ☐ Female

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

Name: _____

Phone Number:_____

Health Care Information

Physician Name:_____ Hospital/Clinic:_____

Address:_____ City, State, Zip Code:_____

Phone:_____ Fax:_____

Medical Information (must be verified 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

The information provided is officially verified when signed and dated by the signature of Health Care Provider below

Health Care Professional: _____ Date:_____

911 4 HNC Financial Assistance Application

Applicant:_____ DOB:_____

Name, Title and Signature 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 ☐ 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: _____

Family Income Sources:

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

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

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

Approximate Annual Household Income: **$_____**

911 4 HNC Financial Assistance Application

Applicant:_____ DOB:_____

Please provide any information about your circumstances that might help us in understanding your need for financial assistance.

_____

_____

_____

_____

_____

_____

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 email this form to: 9114HNC@gmail.com or mail 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.