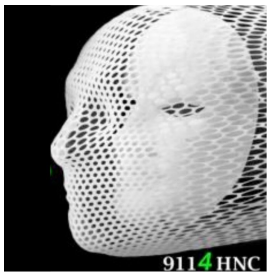
911 4 HNC

Website: https://courageunmasked.org

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: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____

☐ Male ☐ Female

If patient is a minor (under 18), parent/guardian information:

Name: _____ Phone: _____

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

Treatment(s) received in past 12 months:

☐ Radiation Therapy ☐ Chemotherapy ☐ Surgery ☐ Palliative Care

Health Care Professional: _____ Date: _____

Insurance & Household Financial Information

Health Insurance Information

Do you have health insurance? ☐ Yes ☐ No

Do you have dental insurance? ☐ Yes ☐ No

Dental insurance provider / coverage limitations:

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 (check all that apply)

- ☐ Social Security (retirement)
- ☐ Salary
- ☐ Pension
- ☐ Unemployment
- ☐ Public Assistance
- ☐ Short-term Disability
- ☐ SSDI (Disability)
- ☐ SSI
- ☐ Family/Friends provide support

Other – specify:

Monthly amount: $

Household Assets

Checking / Money Market: $ Savings / CDs: $

IRA / 403B / 401K: $ Stocks & Bonds: $

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

Dental / Oral Procedures & Financial Assistance Needs

Dental / Oral Procedures Section (Complete only if applicable)

Is this request for support specifically for a dental procedure or evaluation required prior to cancer treatmen ☐ Yes ☐ No

Does this patient require any dental procedures or oral surgery? ☐ No ☐ Yes

If yes, brief description of service required:

Dental / Oral Physician Name:

Phone: Email:

Practice Name:

Address (Street, City, State, Zip):

Financial Assistance Needs

☐ Prescription medications (describe type):

Dental coverage request submitted to medical insurer? ☐ Yes ☐ No

If denied, has an appeal been made? ☐ Yes ☐ No ☐ N/A

Oncologist letter indicating medical necessity included? ☐ Yes ☐ No

☐ Transportation ☐ Therapeutic Nutrition Products (e.g., Ensure)

☐ Other (please explain):

Amount of Assistance Requested: $

Signature: Date:

Healthcare professional signature required for processing.