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: Patient 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: $

Personal Statement of Need:

Please explain why you are applying for this grant and how receiving it would help you.

We need this information so that we can evaluate your application.

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):

Grant Amount Requested (select one): ☐ $500 ☐ $750 ☐ $1,000

Signature: Date:

Health care professional signature and patient's statement of need are required for processing.