# FINANCIAL APPLICATION FOR PATIENT ASSISTANCE

(*please print*)

 Patient’s Last Name: First Name:

 Address: City/State/Zip:

 Parent/Guardian’s name: **Patient** Date of Birth: / / Age:

 Parent/Guardian’s email: Race/Ethnicity: Language:

 Number of members in the household: Ages of siblings:

# HEALTH INFORMATION

 Child’s diagnosis: Date of Diagnosis:

 Is the child still receiving chemotherapy?  Yes  No Radiation Therapy?  Yes  No

 Child’s Oncologist:

# FINANCIAL INFORMATION

 ***Estimate monthly family expenses: Family Assets:***

|  |  |  |  |
| --- | --- | --- | --- |
| Rent/Mortgage:Utilities: | $ $  | Checking:Savings: | $ $  |
| Phone: | $  | Money Market: | $  |
| Child Care: | $  | **TOTAL:** | **$**  |
| Transportation: | $  |  |  |
| Food: | $  |  |  |
| Medical:**TOTAL:** | $ **$**  |  |  |

 Total monthly family income: $

 *(please include SSI, pension, alimony, public assistance, child support, unemployment, salary, short-term disability, sick leave*

 *pay, support from family and friends)*

 How much fund raising support have you received from your community? $

 Have you received any financial assistance from any organization since your child has been diagnosed

 with cancer?  Yes  No If so, what type of assistance?

|  |
| --- |
| **How much financial assistance are you applying for from the Tommy Fund?**  |
| *TF approval:  Yes  No$* *Approval Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Documentation for any bills must be attached.*** |

 Signature of Parent/Patient (*if patient is over 18 years of age*) Date

PO Box 8295, New Haven, CT 06530

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