# 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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