APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION (PLEASE PRINT CLEARLY) DATE: ______________________

First Name: ______________________ Last Name: ______________________

Address: ______________________ City, State, Zip: ______________________

CONTACT INFORMATION

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email Address: ______________________

Date of Birth: ____________ If under 18, Parent/Guardian Name: ______________________

Male ☐ Female ☐

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MEDICAL INFORMATION

This section MUST be completed by a Nurse, Doctor or Social Worker

Date of Diagnosis: ____________ Primary Cancer: ____________ Stage: ____________

New Diagnosis ☐ Recurrence ☐ Is patient active in treatment? ____________

Please indicate the type of treatment(s) received in past 12 months (check all that apply)

Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative Care ☐

Health care professional information:

MD Name: ______________________ Hospital/Clinic: ______________________

Address: ______________________ City, State, Zip: ______________________

Phone: ______________ Fax: ______________

Name & title of person completing this section:

Phone: ______________ Email: ______________________

Relationship to Applicant: ______________________

Signature of Medical Professional: ______________________

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HEALTH INSURANCE INFORMATION

Does the patient have health insurance? Yes ☐ No ☐

If yes, please indicate type of insurance (check all that apply):

Private Ins ☐ Medicaid ☐ Medicare ☐ Medigap ☐ VA ☐ Charity ☐

Are prescription drugs covered? Yes ☐ No ☐

Annual Deductible: ______________ Coinsurance Amount: ______________

Insurance Carrier: ______________ Policy Number: ______________

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HOUSEHOLD FINANCIAL INFORMATION

Is the patient currently employed Yes ☐ No ☐

Number of people in household: ____________

FAMILY INCOME SOURCES (Check all that apply)

☐ Social Security Retirement ☐ Salary ☐ Pension ☐ Unemployment

☐ Public Assistance ☐ Short-term Disability ☐ SSD (Disability) ☐ SSI

☐ Family/Friends Provide Support Other (Please specify): ____________________________

Total Annual Family Income:

****APPLICATION WILL NOT BE PROCESSED IF THIS INFORMATION IS NOT PROVIDED, INDIVIDUAL MUST ALSO INCLUDE A COPY OF THEIR CURRENT TAX RETURN ****

Family Assets (provide total amount in all accounts that apply)

Checking/Money Market: ________________________ Savings/CDs: ________________________

IRA/430B/401K: ________________________ Stocks & Bonds: ________________________

Total Family Assets: ____

FINANCIAL ASSISTANCE NEEDED (Please Explain)

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Please be aware that funds are limited and based on availability. Patients must also meet Smiley Wiley's eligibility requirements. Our grants are not for living expenses such as rent, mortgages, utility payments or food.

Signature: ________________________________ Date: ____________________

Fax this form to 561 210 8785 or mail to The Smiley Wiley Breast Cancer Foundation, PO Box 4461, Tequesta, FL 33469.

Smiley WIley Foundation will review this information and contact the person requesting financial assistance. All Information is strictly confidential and is for Smiley Wiley's use ONLY.