GIFT OF HOPE

HOPE

Application Form

Applicant's Name: _____ Date of birth: _____

Address: _____

City:_____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work#: _____ Cell#: _____

Best way to reach you? Home ☐ Work ☐ Cell ☐ Best time? _____

Secondary Contact and Phone Number: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Number of Children: _____ Ages: _____ Number of adults living in the home: _____

Language(s) spoken: English ☐ Spanish ☐ Other: ☐ _____

Current Diagnosis

Date Diagnosed: _____ Stage: _____Type: _____

Qualified Treatments

	Date of / date began:	Estimated ending date:	Number of treatments:
Chemotherapy: ☐	_____	_____	_____
Radiation Therapy: ☐	_____	_____	_____

Are you being treated for a recurrence? _____

Your Surgeon: _____

Your Oncologist: _____

Oncology Nurse: _____

Radiation Nurse: _____

Social Worker/Case Manager: _____

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Referral Information

(social worker, oncology nurse, patient navigator, case manager)

First Name:_____ Last Name: _____

Position/Title: _____

Phone #: _____ Email: _____

As the medical referral, my signature attests to the accuracy of the medical information about this patient.

Referral's Signature: _____ Date: _____

Please tell us your reasons for applying to the Gift of Hope: _____

_____

_____

Is there anything else you would like to tell us about yourself and your situation?

_____

_____

_____

Financial assistance from The Gift of Hope is for the duration of qualifying treatments only and shall not exceed a period of 4 months.

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Financial Information

Monthly household income: _____

Current employment: _____

Employer's / Company name: _____

Address: _____

City:_____ State: _____ Zip: _____ County: _____

Phone: _____

Are you taking a leave of absence during treatment? Yes ◯ No ◯

Please attach a copy of the following:

- Last tax return
- Copy of photo ID

I understand that THE GIFT OF HOPE provides free services that all awards are made at the sole discretion of THE GIFT OF HOPE. The information provided in this application is true. I release THE GIFT OF HOPE of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize THE GIFT OF HOPE to release any information including my name, address, and type of assistance provided to any other social service agency at its discretion. I also authorize the release of any medical information and documentation required by THE GIFT OF HOPE for verifying this application and I agree to sign any additional authorizations that may be required. The Gift of Hope terminates all financial assistance on the completion of chemotherapy and/or radiation.

Applicant's Signature: _____ Date: _____

Print Name: _____