HOPE FOR THE JOURNEY/
COMMUNITY FOUNDATION OF THE OZARKS (CFO)

APPLICATION FOR FINANCIAL ASSISTANCE

The Hope for the Journey Foundation provides non-medical financial support to patients facing a life-altering cancer journey and their families. Application for assistance is based on current or on-going consequences of treatment related to cancer and will be evaluated by a committee after completion of this form and verification from your health care provider concerning your cancer status. Preference is given to those residing in Greene, Christian, Taney, Stone, Berry, Lawrence, and Newton counties. Maximum amount available is $1,000.

Patient Name:_____ D.O.B:_____ SS#:_____

Address: _____ City:_____ State_____ Zip:_____

Email:_____ County:_____

Phone No.: _____ If cell, may we text applicant? _____Yes ____No

Employer (if applicable): _____

Medical Diagnosis:_____

Physician(s):_____ _____
name phone

Unless you're an OHA patient, please attach a physician's letter that confirms your diagnosis.

Amount Requested: _____

Please state the intended use for the funds requested. Note: This fund provides non-medical financial support.

_____

_____

Other Agencies from which you are currently receiving funds: _____

_____

What kinds of services are being provided: _____

_____

Health Coverage: ____No ____Yes **If yes, Circle type**: Personal Policy | Employer | Medicare | Medicaid

CFO pays to invoice only. Cash is not provided.

FINANCIAL INFORMATION: (For office use only)

		Monthly Income		Monthly Expenses
Employment:	Patient:	$_____	Rent/Mortgage:	$_____
	Spouse:	$_____	Utilities:	$_____
	Other:	$_____	Food:	$_____
Retirement:	Social Security:	$_____	Insurance Health:	$_____
	VA Pension:	$_____	Insurance Home:	$_____
	Employee Pension:	$_____	Insurance Car:	$_____
Other Income:	Alimony:	$_____	Medical:	$_____
	Child Support:	$_____	Auto Payment:	$_____
	Investments:	$_____	Credit Card Debt:	$_____
	Public Assistance:	$_____	Savings:	$_____
	Workmen's Comp:	$_____	Other Expenses:	
	Unemployment:	$_____	_____	
	Disability:	$_____	_____	
	Insurance:	$ _____	_____	
			_____	

Tell us about your financial situation:

_____
_____
_____
_____

By signing this form, you are agreeing that the Community Foundation of the Ozarks can receive information verifying your cancer status. I hereby certify that I have been diagnosed with cancer and requires financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

_____ _____

Date **Patient Signature**

PLEASE RETURN TO:

Community Foundation of the Ozarks
Attn: Rachel Tripp
PO Box 8960
Springfield, MO 65801

Email: rtripp@cfozarks.org | **Fax:** (417) 864-8344 | **Call:** (417) 864-6199