HOPE FOR THE JOURNEY/

COMMUNITY FOUNDATION OF THE OZARKS (CFO)

APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or on-going consequences of treatment related to cancer. Application for assistance will be individually 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 $1,000.00.

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____

Email: _____ County: _____

Phone#: _____ If cell may we text applicant: _____ Yes _____ No

Employer (if applicable): _____

Medical Diagnosis: _____

Physician(s) Name and Phone Number: _____

_____

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

Amount Requested: $_____

Please state the intended use for the funds requested:

_____

_____

_____

Other Agencies which you are currently receiving funds:

_____

_____

_____

What kinds of services are being provided:

_____

_____

_____

Health Coverage: _____ No _____Yes

If yes, circle type: Personal Policy, Employer Policy, Medicare, Medicaid

Financial Information: (For office use only. This is confidential information and will not be shared)

		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:	_____
	Workman'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 require financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used for eligibility determination. You may be asked to discuss benefits of assistance.

_____ _____

Date Patient Signature

PLEASE RETURN ALONG WITH LETTER WHICH CONFIRMS DIAGNOSIS TO:
Community Foundation of the Ozarks, Attn: Ellen Neville-Verdugo, at PO Box 8960, Springfield, MO 65801

CALL: 417-864-6199 for application questions or **E-Mail**: eneville-verdugo@cfozarks.org