

**PAISLEY COLLINS MEMORIAL FOUNDATION**  
**COMMUNITY FOUNDATION OF THE OZARKS**

**APPLICATION FOR FINANCIAL ASSISTANCE**

Application for assistance is based on current or on going consequences of treatment related to pediatric (age 18 years or younger) cancer. Applications for assistance will be individually evaluated by a committee after completion of this form and verification from your health care provider concerning your child's cancer status. Preference is given to but not limited to those residing in Christian, Douglas, Greene, Howell, Jasper, Newton, Stone, Taney, Texas, Webster, and Wright counties. Maximum amount available is \$1,500 per year. Information provided in this application is strictly confidential and will be used only for the purpose of grantmaking by the Community Foundation of the Ozarks.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ County: \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Phone: \_\_\_\_\_ Other Phone (if applicable): \_\_\_\_\_

Parent/Guardian Employer (if applicable): \_\_\_\_\_

Children and other Dependents at Home (name and age): \_\_\_\_\_

\_\_\_\_\_  
 Patient Medical Diagnosis: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*The Paisley Collins Memorial Foundation committee will contact your physician to confirm your child's diagnosis.*

**Amount Requested (\$1,500 maximum):** \_\_\_\_\_

Please state the intended use for the funds requested: \_\_\_\_\_

Other agencies from which you are currently receiving funds: \_\_\_\_\_

Other services currently being provided: \_\_\_\_\_

Health Coverage: \_\_\_ No \_\_\_ Yes If yes, Circle type: Personal Policy Through Employer Medicaid

**CFO pays to invoice only. Cash is not provided.**

**Paisley Collins Memorial Foundation Application**

**CURRENT FINANCIAL INFORMATION: (For office use only)**

		<u>Monthly Income</u>	<u>Monthly Expenses</u>
Employment:	Parent(s):	\$ _____	Rent/Mortgage: \$ _____
	Guardian:	\$ _____	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:	\$ _____	Other Expenses:
	Workmen's Comp:	\$ _____	_____
	Unemployment:	\$ _____	_____
	Disability:	\$ _____	_____
	Insurance:	\$ _____	_____
	Savings:	\$ _____	_____

<b>Currently owned assets: (i.e.: cars, home)</b>	<b>Value</b>
_____	_____
_____	_____
_____	_____
_____	_____

By signing this form you are agreeing that the Community Foundation of the Ozarks can receive information verifying your child's cancer status. I hereby certify that my child has been diagnosed with cancer and that diagnosis has created a financial burden for which I request assistance. I also certify that the above information is true and correct. All information is confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Parent / Guardian**

**Return applications via mail or scan/email to:**

Rachel Tripp  
 Community Foundation of the Ozarks  
 P.O. Box 8960  
 Springfield, MO 65801  
 rtripp@cfozarks.org  
 Questions? Contact: 417-864-6199