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 $1,000 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 ($1,000 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)

		Monthly Income		Monthly Expenses
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:	$ _____	_____	

Currently owned assets: (i.e.: cars, home)	**Value**
_____	_____
_____	_____
_____	_____
_____	_____

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