SHELLY SACHS 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 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 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 $300**. Information provided in this application is strictly confidential and will be used only for the purpose of grant making by the Community Foundation of the Ozarks. The CFO pays to invoice only. Cash will not be provided.**

Assistance for the following areas will be considered:

- **Pharmacy prescription not covered by insurance**
- **Insurance co-payment**
- **Durable medical equipment (copy of invoice)**
- **Nutritional/grocery assistance**
- **Transportation costs related to medical visits (hotel and/or gas)**

Patient Name:_____DOB:_____

Parent/Guardian Name(s):_____

Home Address:_____County:_____

City_____St____Zip_____ Email: _____

Phone:_____Other Phone (if applicable):_____

Patient/Guardian Employer (if applicable):_____

Spouse Employer (if applicable):_____

Children and other Dependents at Home (name and age):_____

_____

Patient Medical Diagnosis:_____

Physician Name:_____Phone:_____Fax:_____

Amount Requested ($300 maximum amount): _____

Please state the intended use for the funds requested:(Include invoice or bill) _____

_____

_____

Other agencies from which you are currently receiving funds: _____

_____

Health Coverage:____No_____Yes If yes, Circle type: Personal Policy Through Employer Medicaid

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CURRENT 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:	$_____	Other Expenses:	
	Workmen's Comp:	$_____	_____	
	Unemployment:	$_____	_____	
	Disability:	$_____	_____	
	Insurance:	$_____	_____	
	Savings:	$_____	_____	

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

- **Please return along with letter confirming diagnosis from your physician.**
- **Please allow two weeks for a response from Shelly Sachs Foundation after <u>completed</u> application has been submitted.**

<u>Application Checklist</u>

- ☐ **Letter confirming diagnosis from your physician**
- ☐ **Copies of bill/invoice to be paid**
- ☐ **Signed and completed application**

By signing this form, you are agreeing that the Community Foundation of the Ozarks and Shelly Sachs Foundation can receive information verifying 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. You may be asked to discuss benefits of assistance.

_____ _____

Date **Signature of Patient/Spouse/Guardian/Other**

Return completed application via mail or scan/email to:

Community Foundation of the Ozarks
Attn: Rachel Tripp
P.O. Box 8960
Springfield, MO 65801
rtripp@cfozarks.org

Questions? Contact: 417-864-6199