Application for Assistance

Patient Name:_____

Spouse/Primary Caregiver:_____

Physical Address:_____

Mailing address_____

Name the check to be made out to:_____

Email address:_____

Phone Number:_____cell_____

Date of Birth:_____

Place of birth:_____

STJ resident_____for how long_____

Employer:_____

Employer address:_____

Employer phone number:_____

Date of Diagnosis: Month_____ Year_____

Cancer Type:_____

Race(optional): ____Black:_____Caucasian/White:_____Hispanic:___Asian:

Other_____

Requirement for all requests:

You must return copies of the following documents with this application:

1. **Physician Verification Form must be completed and signed by** your Physician, or you may present a letter with the diagnosis and treatment recommended by your Physician.
2. **Signed St John Cancer Fund application**

Request for Financial Assistance

Request for assistance: Please **explain in detail what you are asking St John Cancer Fund to help with. Please provide us with the dollar amount requested. Please provide receipts and copies of any bills you require reimbursement for.**

_____
_____
_____
_____
_____
_____

I understand, should I be approved for financial assistance while I am receiving treatment; this assistance will pay up to $4000.00 dollars per patient per year. Should I reach the allotted amount, I understand that I must make other financial arrangements for the duration of my treatment; and I will be financially responsible for same.

I have read and understand the above conditions to receive financial assistance. I swear all statements in this application are true and correct. All information provided will be held in the strictest confidence and will not be shared with any other group or entity.

I accept that any decision made by St John Cancer Fund with regard to my application is final.

_____ _____

Signature of Applicant Date

Please scan and return form and documentation to: stjohncancerfund@gmail.com questions? Contact Cynthia Smith 340-513-0514