

CANCER FOUNDATION OF THE FLORIDA KEYS, INC

KEY WEST, FLORIDA 33045-5818

305-294-7300

APPLICATION FOR ASSISTANCE

FAX TO 305-745-8686

Date: _____

Social Security Number: / /

Applicant's Name: _____

Sex: Male / Female

(first, middle, and last)

DOB: / /

Medical Insurance: Yes / No

Terms(%,\$ of Co-Pay/Deductibles): _____

Medical Insurance Provider: _____

Proof of Monroe County Residency (ID Type: Example D/L, V/R, SHtrVrctn): _____

Proof of Monroe County Residency (ID#): _____

Reason For Assistance(Include Diagnosis): _____

Help Needed: _____

Other Agencies Applied To: _____ / _____ / _____ / _____
Agency Contact Person Agency Contact Person

_____ / _____ / _____ / _____
Agency Contact Person Agency Contact Person

Applicant's Contact Information: h () - _____ w () - _____

c () - _____

* fax number () - _____ *must be provided

* e-mail address _____ *must be provided

physical address if different: _____

Previous address if less than one year: _____

Physician Contact Information: phone () - _____ additional # () - _____

* fax number () - _____ e-mail address _____

Physician Contact Information: phone () - _____ additional # () - _____

* fax number () - _____ e-mail address _____

Applicant's Emergency Contact: _____ Relationship: _____

* Emergency Contact Person will be (first, middle, and last)

contacted if we are unable to contact h () - _____ w () - _____

the applicant, especially if it is necessary c () - _____

after approval. * fax number () - _____ *must be provided

* e-mail address _____ *must be provided

mailing address: _____

CANCER FOUNDATION OF THE FLORIDA KEYS, INC

KEY WEST, FLORIDA 33045-5816
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APPLICATION FOR ASSISTANCE

(continued Application Page 2):

FAX TO 305-745-8686

INCOME/EXPENSE INFORMATION:

**Monthly income for household: \$ _____

Occupation/Source of Income: _____

Other Income (ex.SS/ATD): \$ _____

Savings/Disposable Assets: \$ _____

Life Insurance: Yes / No _____ Value: \$ _____

Life Insurance Company: _____ Policy No.: _____

IRA: Yes / No _____ Value: \$ _____

Other Investments: _____ Value: \$ _____

***Monthly Expenses:		\$ _____	\$ _____
Payment Type	Amount	Payment Type	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

****Attach Current Tax Return(s)**

*****Attach copy of all bills listed for rent/mortgage attach copy of lease/mortgage payment/verification of housing**

CONSENT FOR ENROLLMENT:

I understand and agree information supplied by me may be shared with other funding sources and community services, for benefits and planning on my behalf. I attest that I am a resident of Monroe County, and that I must pursue all relevant Federal, State, local, public and private resources for medical and financial assistance, in a timely fashion before, or coincidental with, receiving any financial assistance from the Cancer Foundation of the Florida Keys. I understand that I may become ineligible for services if, at any time, I have been found to have deliberately misled any representative of the Foundation. I further understand that any help I may receive from the Foundation shall be at their discretion, and in consideration for the Foundation accepting my application and considering it, I agree to indemnify the Foundation and hold it harmless from any liability associated with their review and decision regarding my application.

APPLICANT SIGNATURE: _____ DATE: _____

APPLICANT PRINTED NAME: _____ DATE: _____

_____ DATE: _____

WITNESS SIGNATURE _____ WITNESS PRINTED NAME _____

FOR INTERNAL USE ONLY:			
Date Completed Application Received:	____ / ____ / ____	MM/DD/YYYY	
Date Application Approved/Denied (circle one):	____ / ____ / ____	MM/DD/YYYY	
Diagnosis:	_____		
Date Treatment Begins:	____ / ____ / ____	MM/DD/YYYY	FollowUpDate ____ / ____ / ____ MM/DD/YYYY
Estimate Date Treatment Ends:	____ / ____ / ____	MM/DD/YYYY	FollowUpDate ____ / ____ / ____ MM/DD/YYYY
Date Assistance Ends:	____ / ____ / ____	MM/DD/YYYY	FollowUpDate ____ / ____ / ____ MM/DD/YYYY

CANCER FOUNDATION OF THE FLORIDA KEYS

KEY WEST, FLORIDA 33045-5816

TELEPHONE 305 294-7300

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the Cancer Foundation of the Florida Keys to obtain from

Dr. _____

Address: _____

any and all information pertaining to my diagnosis of cancer and treatment of that disease. This information will be obtained upon application for financial assistance and every six months as long as I am their client.

1. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Chairman of the Grants Committee.
3. I understand that if I refuse to sign, or, at any time revoke this authorization, I will become ineligible for financial assistance from the Cancer Foundation Of The Florida Keys.

Date

Patient Signature or Legal Representative

Witness Signature

The Cancer Foundation of the Florida Keys is an all-volunteer, Keys-wide, non-profit organization dedicated to assisting needy cancer patients while they are undergoing treatment for their disease. We receive no government funds--all of our income is derived from donation jars placed throughout the county, events held by others, and donations from individuals. There are no administrative costs deducted from these donations-we all work out of our homes.

As we discussed in our recent telephone conversation, I am sending you our 'Client Contact Form'. You *must* complete the entire form and enclose it with *all of the required information listed below*:

1. Letter(s) from your physician(s) showing diagnosis and proposed treatment.
2. A copy of your lease, if any. If you do not have a lease, please furnish us with a statement from your landlord, listing the amount of your rent payment and any utilities that may be included.. You may also submit a 'Shelter Verification' form available from the Department of Children and Families 1111 Twelfth St, Key West, Florida 33040, Telephone 292-6719. Please print the names of all signers of the document legibly under their signatures.
3. Copies of current bills due (rent, utilities, and other living expenses). NO MEDICAL BILLS.
4. A signed *Release for Medical Information* (enclosed) from your physician(s). Give a copy of this completed release form to your physician(s) to keep in your medical record.

Please return the completed application form with all of the required documentation to:

Lanny Skelly, Grants Chairman
17013 Coral Drive
Sugarloaf Key, Florida 33042-3541

or
FAX to me at 305-745-8686

Upon receipt of your completed application, I will submit it to the Grants Committee for approval. This process may take up to a week. I will notify you as to the decision of the Grants Committee.

If you are approved for financial assistance, please do the following:

1. Submit Housing requests between the 15th and the 20th of the month for the following month. *This is a must!*
2. Submit your other bills as you receive them. Notify your utility providers that you are undergoing treatment for cancer so that they can flag your account for consideration if your payments may be late.

FAX ALL REQUESTS TO: 292-0187 BETWEEN 8:30 AM AND 6:30 PM

We emphasize the importance of attending a support group. The Tuesday group for all types of cancer meets from 5-6 PM at the Hospice-VNA Building on William Street in Key West. The breast cancer group meets on Wednesdays at the same time and place.

We wish you every success in your treatment and recovery. We are here to assist you as much as possible during this difficult time and will do everything possible to alleviate your stress. If you have any questions or have to contact me, I can be reached at home between 9:00 AM and 7:00 PM at 745-1394.

Sincerely

Lanny Skelly, Grants Chairman

KEEP THIS LETTER HANDY