Stomp Out Cancer Fund
Financial Assistance Request Form

We are a nonprofit organization providing limited financial & educational assistance to children and adults undergoing cancer treatment in **MANISTEE** and **MASON COUNTY**. You must reside in one of the counties we serve in order to be eligible for financial assistance. If you are requesting financial assistance please fill out this form and mail it to us at the address below. We process request forms monthly and will contact you when your request is reviewed.

Please email us at info@soc-fund.org, if you have questions.
SOC FUND PO Box 783, Manistee, MI 49660

Patient Information

Patient Name ____ Date of Birth _____________________

Address ____ City ____________________________________

State ________________ Zip Code ___________________ ☐ Seasonal Resident ☐ Permanent Resident

Home Phone Number ______________________________ Cell Phone Number __________________________

Referred by ______________________ How did you hear about us? ________________

Medical History

Cancer Diagnosis ____

Are you currently undergoing cancer treatment? ☐ NO ☐ YES If yes, ☐ Chemo Therapy

☐ Radiation Therapy ☐ Alternative Therapy Explain ____

Financial Information

Are you the primary income in your household ☐ NO ☐ YES Number of people in your household? ______

Reported Annual Household income __________________ Do you have Medical Insurance ☐ NO ☐ YES

Are you receiving Disability benefits due to the cancer? ☐ NO ☐ YES If yes, weekly amount and duration?

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What do you need financial assistance with: Amount Requested $____________________

☐ Travel Lodging ☐ Medical Co-pays ☐ Utilities ☐ Pharmaceuticals ☐ Alternative therapy

☐ Other ____

Comments: ____

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Have you requested or received financial assistance for the above? If so, please provide the amount requested/received, who you have applied/received funds from (for the above only) and their contact information ____

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I verify that the information provided in the application is complete and accurate. I further understand that I may be asked to provide proof of the reported financial information on the application if asked by the SOC FUND. I verify that I have provided the information for payment/pending payment for financial assistance from sources other than the SOC FUND.

I recognize that the SOC Fund is providing full or partial financial assistance for the service described in this application as deemed medically necessary by my healthcare provider (s). SOC Fund is in no way liable for the success/failure of this service or for any harm to my health that it may cause. I authorize the SOC Fund and its agents to obtain and discuss information related to the application process with my prescribing physician, pharmacy, employer, insurance company, or other organizations working on my behalf of obtaining services. The SOC Fund and/or its agents or authorized designee agrees not to disclose any individually identifiable information to any third party, except as provided herein or except as required by law. The SOC Fund can, however, use the data to develop aggregate reports as directed by its Board of Directors.

I understand that the SOC Fund reserves the right at any time and without notice to modify or discontinue any or all of the programs with respect to any applicant or in their entirety, to modify the related eligibility criteria, or to terminate assistance at any time.

Patient Signature ____ Date ________________________

Physician Name ____ Phone Number__________________________

PLEASE PRINT

Physician Signature____ Date ________________________

****For Inner Office Use****

Additional Questions: ____

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Answers/Comments: ____

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Amount Approved $ ____ Date ______________________________

Patient Notified ☐ YES Comment____

Signature____Date ____________________

Date Funds Dispersed _________________________________ Initials ______________ & Initials ______________

Updated 5-29-13 rv