

**Applicant**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

**Person Completing Application**

I am the applicant  
 I am assisting the applicant (please indicate name and relationship)  
 Your name \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

**Cancer Information**

Diagnosis \_\_\_\_\_  
 Cancer Stage  
 I  O  
 II  None Specified  
 III  Remission  
 IV  Recurrent

Current Treatment  
 Chemotherapy  Hormone therapy  
 Radiation  Immunotherapy  
 Clinical trials  Hospice  
 Surgery  Recovery  
 Transplant  Follow up monitoring

Clinic/Hospital \_\_\_\_\_  
 City \_\_\_\_\_  
 Oncologist \_\_\_\_\_

**Hardships**

Please check all that apply.

<input type="checkbox"/> Reduced work hours	<input type="checkbox"/> Increased expenses due to treatment	<input type="checkbox"/> Limited or no emergency funds
<input type="checkbox"/> Unable to work	<input type="checkbox"/> Extreme circumstances	<input type="checkbox"/> Lodging for treatment
<input type="checkbox"/> Increased childcare	<input type="checkbox"/> Terminal diagnosis	<input type="checkbox"/> Transportation for treatment
<input type="checkbox"/> High out-of-pocket medical costs	<input type="checkbox"/> Increased financial stress and/or debt	<input type="checkbox"/> Limitations on daily life
<input type="checkbox"/> Housing or utility concerns	<input type="checkbox"/> Difficulty affording basic necessities	<input type="checkbox"/> Other _____

**Hardship Statement**

Please briefly describe the financial hardship and any other information as a result of your cancer diagnosis or treatment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check here if additional pages are attached

**Self-Attestation (Required)**

I certify the information in this application is true and accurate to the best of my knowledge.  
 I understand that this assistance is intended for cancer-related financial hardship.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

*Additional information may be requested upon committee review.*

Would you be interested in sharing your story at our annual event, Little Black Dress Gala?  Yes  No

How did you hear about us?  Cancer Center  FaceBook  Friend/Family  Event  
 Other \_\_\_\_\_

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