Financial Application

Filling out this financial application completely helps us determine your eligibility for both our services & other regional and national services. We always keep your personal information private.

Thank you in advance for assisting us by providing the information needed to help us to serve you the best way possible!

CANCER SERVICES
Enhancing Health, Life, & Survivorship

Date: _____

Client First Name: _____ MI: ___ Last Name: _____

Date of Birth: _____ SS#: _____

Best Phone # to Reach You: _____ ☐ Home ☐ Cell ☐ Work

In order for us to identify resources for you please explain your most urgent financial needs and concerns.

Number of people living in your household (Including yourself): _____ Please List Below:

Name	Relationship	Has Income? Yes or No	Age

Other Health Conditions & Prescription Medications

Health Conditions (check all that apply)

☐ Arthritis ☐ Asthma ☐ COPD ☐ Diabetes ☐ Osteoporosis ☐ Heart Conditions
☐ High Blood Pressure ☐ High Cholesterol ☐ Other (specify) _____

Cancer Related Prescription Medications: _____

_____

_____

Non-Cancer Prescription Medications: _____

_____

Monthly Income & Household Expenses *Please provide proof of the household income.	
Client Monthly Income	**Spouse/Children/Other Monthly Income**
Child Support	Child Support
Disability	Disability
Employment/Unemployment	Employment/Unemployment
Social Security	Social Security
Retirement	Retirement
Interest/Investment/Rental Income	Interest/Investment/Rental Income
Food Stamps	Food Stamps
Other Income	Other Income
TOTAL	**TOTAL**

Monthly Living Expenses	Amt Paid Monthly	Monthly Living Expenses	Amt Paid Monthly
Rent / Mortgage		Medical Bills	
Electricity/Gas		Credit Cards	
Water / Sewer / Garbage		Loans	
Telephone / Cell Phone		Medical / Life Insurance	
Cable/Internet		Car / House Insurance	
Car Payment		Property Taxes	
Vehicle Fuel		Child Care/Child Support	
Prescriptions – Non-Cancer		Food	
Prescriptions – Cancer		Other:	
TOTAL		**TOTAL**	

Total Monthly Net Income	
Total Monthly Living Expenses	
Net Balance – Surplus or (Deficit)	

**I agree that the information provided to Cancer Services is correct to the best of my knowledge and I will provide any updates regarding household income, insurance coverage and treatment status.

Client Name or Representative (Printed): _____Relationship: _____

Signature: _____ Date: _____

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Approved Assistance	From	To
Medication		
Nutrition Shakes		
Gas Cards / Rides		
Crisis Assistance		
Lymphedema /Mastectomy		
Ostomy / Trach		
Other:		

Eligible for Assistance? Yes / No % FPL_____

PT Advocate Interviewer:

_____

Date: _____

Approved By
(PA Director or CEO): _____

Date _____