Jen's Friends Cancer Foundation

PO Box 1842

North Conway NH 03860

603-356-5083

www.Jensfriends.org

APPLICATION FOR ASSISTANCE

Please complete this application including all signature spots. Once your application is received a volunteer from Jens Friends will contact you. All decisions for assistance are made by our Disbursement Committee. Only completed applications can be considered.

Last Name_____ First Name_____

Physical Address_____

Town_____ State:_____ Zip_____

Mailing Address_____

Town_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email address_____

Person other than patient we can reach. Name_____

Phone_____ Relationship _____

*****MEDICAL INFORMATION *****

To be completed by your Oncology Nurse, Doctor,

Social Worker, or Hospital Patient Navigator *only*.

Primary Cancer_____ Date of Diagnosis_____

Current Stage_____ Is patient in active treatment Y/N_____

Provider Name_____ Hospital/Facility_____

____New Diagnosis ____Recurrence

If not in active treatment how often is follow up ___yearly ___6 months ___other

Name of person completing the section_____

_____Provider ____RN _____Social Worker _____Hospital Patient Navigator

Signature_____ Contact number_____

Date:_____

******To be completed by patient requesting assistance******

Patient Name_____ DOB_____

HEALTH INSURANCE INFORMATION

____Private Insurance _____Medicare ____ Medicare + Medi-Gap

____Medicaid _____VA _____Prescription Coverage

_____Charity Care _____Un- Insured

FINANCIAL IMFORMATION

Patient Employer _____Number of Household Members_____

Employment or other income of Household _____

_____ Salary _____Pension _____Disability _____Social Security

_____Unemployment _____Public Assistance _____Other

Total annual (Family) Income $_____

Housing_____ ____Rent ____Own Monthly Cost $_____

Electric Company _____ Monthly Cost $_____

Winter Heating _____ Monthly Cost $_____

Telephone Company _____ Monthly Cost $_____

Other (HOA, car payments etc)_____

_____ Monthly Cost $_____

FINANCIAL ASSISTANCE - PLEASE TELL US WHAT WE CAN HELP YOU WITH

_____

_____

_____

Jen's Friends is a 100% volunteer organization. Funds are raised by your friends, neighbors, and community. We are pleased to be able to provide support and assistance when applicable. In return we ask that you be honest and respectful in your requests and remain good stewards of this community organization. Once you have completed and returned this application a member of the disbursement committee will contact you for a brief review of your needs. You will be assigned a Jen's Friends Clinical Contact who will reach out to you monthly for updates. You can submit this application by mail, email or drop it at the Oncology Department at Memorial Hospital.

***By way of my signature, I attest the above information to be true and accurate*:**

Signature_____ Date: _____

All submitted information is confidential.