Community Cancer Center

Application for Financial Assistance

Name: _____ SS#:_____ Birthdate: _____

Address: _____ Telephone: _____

Former Address: _____

(If at present address less than two years)

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Spouse's Name:_____ SS#:_____

Number in Household: _____ Number of Dependent Children at Home: _____ Ages: _____

MONTHLY HOUSEHOLD INCOME PLEASE PROVIDE PROOF OF INCOME

Name of Person Employed	Name of Employer	Length of Employment	Monthly Gross $	Monthly Net $
			$	$
			$	$
			$	$

All Other Income Not Listed Above (List Sources):

	$	$
	$	$
TOTAL MONTHLY INCOME		$

MONTHLY LIVING EXPENSES

	Monthly Payment
Home: ❒ Own ❒ Rent _____	$
Automobile: Gas _____ Maintenance & Repairs _____	$
Food & Household Items: _____	$
Utilities: Gas _____ Electricity _____ Water _____ Phone _____	$
Insurance: Life _____ Health _____ Auto _____ Other _____	$
Medications: _____	$
Miscellaneous (Clothing, Child Care, School, Etc.): _____	$
TOTALS from Page 2: A _____ B _____ C _____	$
TOTAL MONTHLY LIVING EXPENSE	$

ASSETS CASH AND INVESTMENTS

Bank and Branch	Type of Account	Account Balance
		$
		$
		$
	TOTAL ASSETS	$

CHARGE CARDS MASTERCARD, VISA, DEPARTMENT STORES

Bank and Branch	Account Balance		Monthly Payment
		$	
		$	
		$	
		$	
		$	
TOTAL CHARGE CARD EXPENSE (A)		$	

OTHER CREDITORS AUTO/RV LOANS, ETC.

Bank and Branch	Account Balance		Monthly Payment
		$	
		$	
		$	
TOTAL OTHER CREDITORS EXPENSE (B)		$	

MEDICAL CREDITORS

Provider Name	Account Balance		Monthly Payment
		$	
		$	
		$	
		$	
		$	
TOTAL MEDICAL CREDITORS EXPENSES (C)		$	

The above information is warranted to be true.

I hereby authorize any Credit Bureau or other investigative agency employed by Community Cancer Center to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date: _____ Signature of Applicant: _____

FOR OFFICE USE ONLY:

Estimated Patient Responsibility: CCC $_____ RM/MB $_____

Discount Approved/Denied: ED: _____ Physician: _____ ❑ Denied

❑ Approved Based on Income _____% ❑ Approved Based on Income/Expense _____%

Patient informed by: ❑ Letter ❑ In Person By _____on _____(Date)