



# Connor Moran Children's Cancer Foundation

## Patient/Family Application for Assistance

Patient Name \_\_\_\_\_ Diagnosis Date \_\_\_\_\_ Type of Illness \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Alternative Phone Number (cell, relative) \_\_\_\_\_

Email: \_\_\_\_\_

Parent(s) Name if NOT PATIENT \_\_\_\_\_

Children (living at home) and ages \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Have you applied for:

<input type="checkbox"/> Medicaid	When? _____	Approved? _____	\$ _____
<input type="checkbox"/> Food Stamps	When? _____	Approved? _____	\$ _____
<input type="checkbox"/> SSI	When? _____	Approved? _____	\$ _____

To better serve you, please check or list all other organizations you are currently working with for assistance; (GAL, Social Services, Adopt a Family, Cancer Alliance, POST, Little Smiles, SF Kids Cancer, Celebrities FORE Kids, Jessica June, LLF, Gilda's Club, Diamond Angels, Blue Water Babes, Wish Organizations, etc.)

### What do you need assistance with:

	Monthly Payment	Due Date
Rent/Mortgage	\$ _____	_____
Car Insurance	_____	_____
Health Insurance	_____	_____
Auto Loan(s)	_____	_____
Utilities (electric, water, phone)	_____	_____
Credit Card Debt	_____	_____
Medical Bills	_____	_____
Clothing <input type="checkbox"/> Gas <input type="checkbox"/> Food <input type="checkbox"/> Home Repairs <input type="checkbox"/> Tutoring <input type="checkbox"/> Respite <input type="checkbox"/> Other _____		

I certify with my signature that to the best of my knowledge the information I have provided is complete and accurate. I understand that the information I have given is subject to verification by the Connor Moran CCF. I also understand that I am responsible to inform CMCCF of any change in my status. I grant permission to CMCCF to use/release my information submitted, and disclose and request on my behalf to other agencies, providers, doctors and medical facilities for the purpose of case management, assistance, and advocacy, and understand that I can revoke this permission at any time in writing. Information may be shared verbally or by computer data transfer, mail, or hand delivery. I further understand that CMCCF is a privately funded organization and the final determination of granting of financial assistance is based on the availability of funds, and the governance of its board of directors.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Please submit application to:

Connor Moran Cancer Foundation  
401 Old Dixie Hwy., Suite 4221, Jupiter, FL 33469 PH:  
561-741-1144 FX:561-741-1144