Connor Moran Cancer Foundation

Patient/Family Application for Assistance

Date___/___/___

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 _____

Referred By_____ Phone_____

Primary Physician_____ Phone_____

Do you have Health Insurance? _____ If yes, please complete the following:

Insurance Company Name _____

Policy and Group # _____ Phone _____

Have you applied for:

- ☐ Medicaid When? _____ Approved? _____ $_____
- ☐ Food Stamps When? _____ Approved? _____ $_____
- ☐ 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 ☐ Gas ☐ Food ☐ Home Repairs ☐ Tutoring ☐ Respite ☐ 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