



Connor Moran Cancer Foundation

Patient/Family Application for Assistance

Date ___/___/___

Patient Name _____ Diagnosis Date _____ Type of Cancer _____

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? _____ \$ _____
- Social Security Disability When? _____ Approved? _____ \$ _____
- Drug Compassion Program When? _____ Company Name _____ \$ _____

Please list other organizations contacted regarding assistance (Social Services, Catholic Charities, etc.)

Agency	Contact Person	Benefits Rec'd

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"/> Transportation <input type="checkbox"/> Food <input type="checkbox"/> Home Repairs <input type="checkbox"/> Other <input type="checkbox"/>	_____	

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 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. 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 qualification for financial assistance is by 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: 561-748-7227 FX:561-741-1144