Cancer Care
Community Advisory Board
"CABbies"

Telephone: 508-828-0405
Fax #: 508-386-0128
www.cancercarecabbies.com

The CABbies is a not-for-profit 501 (c) (3) organization

FINANCIAL ASSISTANCE APPLICATION

Please note that completed applications can take 4 to 6 weeks to process

ALL APPLICATIONS MUST BE FAXED BY THE HEALTH CARE FACILITY

PATIENT INFORMATION (please print clearly)

Date: _____/_____/_____

Name: _____ Age: _____ Date of Birth: _____/_____/_____ Male ____ Female____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Other ____

Street Address: _____ Apartment #: _____

City: _____ State: **MA** Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Medical Insurance Carrier: _____

If Patient is a minor (under 18) Name of parent(s) or guardian(s):

_____

How did you hear about the CABbies: _____

Briefly explain your circumstances and how your cancer diagnosis has created a financial hardship:

_____

_____

_____

_____

_____

_____

HOUSEHOLD FINANCIAL INFORMATION

*PLEASE LIST BELOW **ALL** OF THE PEOPLE IN YOUR HOUSEHOLD*

Number of people in household: _____

Name	DOB	Relationship to Patient	Employer, Employment Full/Part Time/Retired/Self-Employed/ Unemployed/Disabled/Child/Student	Yearly Income
1) _____	___/___/___	**Self**	_____	$_____
2) _____	___/___/___	_____	_____	$_____
3) _____	___/___/___	_____	_____	$_____
4) _____	___/___/___	_____	_____	$_____
			Total Family Income	$_____

____ **I have attached copies of my income sources** (most recent award letter, benefit statement, checks, or pay stubs).
You must submit copies to verify your total annual income.

____ Social Security (retirement) ____Salary ____Pension ____Unemployment ____ Child Support/Alimony
____ Public Assistance ____ Short Term Disability ____ SSD (disability) ____SSI ____ Go Fund Me/Similar
____ Workers Compensation ____ Veterans Benefits ____ Rental Income ____ Family/Friends provide support
____ Other-specify: _____

IF YOU CHECKED ANY OF THE ABOVE BOXES, PLEASE COMPLETE THE FOLLOWING SECTION

Name	Type of Income	Amount	How often is the income received	Date the income started
_____	_____	$_____	_____	_____/_____/_____
_____	_____	$_____	_____	_____/_____/_____
_____	_____	$_____	_____	_____/_____/_____

Have you applied to other agencies for assistance? _____ YES _____ NO

If Yes which ones? _____

We strongly encourage you to seek assistance from any and all resources. Assistance from other agencies will not impact eligibility with The CABbies.

What is the total amount of money you currently have in the bank? Please include checking accounts, savings accounts, CDs and IRAs: $_____

FINANCIAL INFORMATION

So that we can have a clear picture of your financial situation, please list all of your **monthly** living expenses, each one on a separate line:

____ Rent ____ Mortgage Monthly amount: $_____
Landlord or Mortgage Company: _____
Address: _____ City: _____ State: _____ Zip: _____

	Company or Provider	Monthly Amount
HomeOwners or Renters Insurance*:	_____	$_____
Property Taxes*:	_____	$_____
Electric/Gas:	_____	$_____
Phone:	_____	$_____
Heat (if oil):	_____	$_____
Water:	_____	$_____
Cable/Internet:	_____	$_____
Credit Card(s):	_____	$_____
Car Payment:	_____	$_____
Car Insurance:	_____	$_____
Other: (Specify)	_____	$_____
	Groceries:	$_____
	Gasoline:	$_____

(Only include Homeowners Insurance and Property Taxes if these are paid by you directly instead of by the mortgage company through escrow.)*

Please choose the two most important expenses that you would like to be **considered** for financial assistance. Please attach copies of bills you would like considered. You do not need to list where you purchase your groceries or gasoline just list the monthly total: ***The copy must include: the name on the account, account number, a current due date, amount due and remit to address.***

1) Amount Requested: $_____ Account #: _____
Make check payable to: _____
Address: _____
_____

2) Amount Requested: $_____ Account #: _____
Make check payable to: _____
Address: _____
_____

Did you work before your diagnosis? ____ Yes ____ No ____ Part Time ____ Full Time

Will you be able to return to work after your treatment? ____ Yes ____ No ____ Part Time ____ Full Time

If you will not be able to return to work as before, please explain the reason as you understand it.

_____

_____

_____

_____

_____
Patient Signature

_____ _____/_____/_____
Please Print Full Name Date

MEDICAL INFORMATION RELEASE

I, _____ hereby release: _____
(Patient Name) (Physician Name)

and members of his or her staff to communicate via letter or telephone with The CABbies and its representatives for the purposes of confirming that I am a patient being treated for: _____ .
(diagnosis)

_____ _____/_____/_____
(Patient Signature) Date

Financial Hardship Summary

To be COMPLETED and FAXED by Health Care Provider

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Health Care Professional Name: _____

Hospital/Medical Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

I certify that the above information is accurate and correct.

_____ _____/_____/_____

Health Care Professional Signature Date

TREATING PHYSICIAN (to be completed by Treating Physician)

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

Patient's Diagnosis: _____ Stage: _____

Date of Diagnosis: _____/_____/_____

Is the Patient in active treatment or maintenance? _____ Active _____ Maintenance

What is the projected length of treatment? _____

What is the treatment? (please be specific) _____ Oral _____ IV _____

Is the patient able to work during treatment? _____ Yes _____ No

Is the patient able to return to work after treatment? _____ Yes _____ No

Physician's Name: _____

Hospital/Medical Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Physician's NPI: _____

I certify that the above information is accurate and correct.

_____ _____/_____/_____

Treating Physician's Signature Date