Jolly John's "Keep You Truckin" Fund, Inc

Attn: Donna Wallace, PO Box 308, Columbia, CT 06237

Email: dwallace@columbiaford.com Phone: 860-228-2886 ext 151**Fax: 860-228-0472**

APPLICATION FOR ASSISTANCE FOR CT RESIDENTS ONLY

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

First Name: Last Name: Middle Initial:

Address (No PO Box): City, State, Zip:

Phone number: Home ( ) Work ( ) Cell ( )

Email Address: Date of Birth:

If patient is a minor (under 18), name of parent or guardian:

Male Female ------ Ethnicity: White African American Latino Asian Other

*****MEDICAL INFORMATION *** THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY**

Date of Diagnosis: Primary Cancer: Current Stage:

New Diagnosis: Recurrence : Is patient in active treatment? Yes No

If not in active treatment, indicate frequency of follow-up: Yearly Every 6 months Other

Please indicate type of treatment(s) received in past twelve months (check all that apply)

Chemotherapy Radiation Surgery Hormonal Palliative Care Bone marrow/stem cell transplant

***** PLEASE COMPLETE ALL FIELDS ABOVE AND PROVIDE A BRIEF SUMMARY ON BEHALF OF PATIENT*****

HEALTH CARE PROFESSIONAL INFORMATION (PLEASE PRINT CLEARLY)

Physician Name: Hospital/Clinic:

Address: City, State, Zip:

Phone: ( ) Fax: ( )

Name and title of person completing this section, if different than above (please print):

Phone: ( ) Email Address:

Your relationship to person applying for help: Doctor Nurse Social Worker

Signature of MEDICAL Professional:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? Yes No

If yes, please indicate type of insurance (check all that apply):

Private insurance Medicaid Medicare Medicare plus Medigap Charity care VA program Husky

Are prescription drugs covered? Yes No

Is Dental covered? Yes No

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HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ☐Yes ☐No Number of people in household:

Family Income Sources (please check all that apply):

☐Social Security (retirement) ☐Salary ☐Pension ☐Unemployment ☐Public Assistance ☐Short-term Disability

☐SSD (Disability) ☐SSI ☐Family/friends provide support ☐Other - specify

Acceptable proof of income:**

First two pages of signed copy of income tax return (you may blacken social security #)

OR

If you do not file a tax return: Copies of most recent pay check, unemployment check, SSI, SSD, public assistance benefit notification

Total Annual Family Income	**$**

*****Application will not be processed if this information is not provided*****

FINANCIAL ASSISTANCE NEEDS (PLEASE CIRLCE ALL THAT APPLY)

**I need help with the following cancer-related Living/Medical expenses.

Rent ☐Mortgage ☐Utility Bill ☐Insurance Deductible Insurance Payment Medical Bill Dental Bill ☐ Mastectomy Bras Other

** Copies of most recent lease, billiing statements and a complete W9 for each entity you are requesting payment to

Relationship to person applying for help:

☐Self ☐Spouse ☐Family member/caregiver ☐Health care professional

I hereby acknowledge and represent the information provided is true, correct and complete to the best of my knowledge. I further understand that false information constitutes grounds for refusal of Jolly John's "Keep You Truckin" Fund. By way of my signature I attest that any financial assistance provided will be used for the expense indicated above.

Patient Signature: ____ **Date:**_______________

*******All expenses will be paid by check directly to the service provider from fund.*******

Please be aware that funds are limited and based on availability as well as on meeting eligibility requirements.

Date Received:____

Approved or Denied Date:____

Amount Approved: ____________________**Paid Date:**_________________________**Ck#**_______________