AVERY FOUNDATION

APPLICATION FOR FINANCIAL ASSISTANCE

Name: _____ Date of Birth: _____
Last (Please Print) First M.I. mm/dd/yyyy

Address: _____
Street Address Apartment / Unit #

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____
Last First

Travel Destination for Treatment: _____
Hospital / Clinic Name City State

Treatment Travel Dates	Hotel Stay Needed		Meals Needed	
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No

Household Income: Verification Required

Gross Income per month: _____ Attach copies of pay stubs for the last 30 days
or
Gross Income per year: _____ Attach copy of most recent tax return

For Health Care Provider Use

Diagnosis: _____

The individual named above is under my/our care for cancer related treatment

_____ _____

Name of Provider (Please Print) Signature of Provider Date

Because the assistance provided by the Avery Foundation is based on need, income verification is required to ensure that support goes to those most in need of help. Please attach the following documents to this application:

1. Copies of pay stubs for the last 30 days or a copy of the most recent tax return
2. All dated receipts for hotel stays
3. All meal receipts showing the number of people served and the type of meal consumed (breakfast, lunch, dinner)

Available reimbursement:

1. Mileage: Paid at $0.45 per mile (Mileage determined by MapQuest)
2. Hotel stays: Paid up to $75.00 per night
3. Meals are paid as follows:
    a. Breakfast: Paid up to $7.00 per person
    b. Lunch: Paid up to $10.00 per person
    c. Dinner: Paid up to $15.00 per person

ALL INFORMATION RECEIVED IS STRICTLY CONFIDENTIAL AND ACCESSIBLE ONLY TO THE AVERY FOUNDATION BOARD OF DIRECTORS

Signature of Applicant: _____

Signature of parent / guardian if under 18 years of age: _____

Date: _____