Financial Assistance Application Form - 2024

Complete this patient application to apply for assistance from Jessica's Heroes Foundation. Patient must be receiving treatment or Hospice care and live/reside in the city of Oneida or surrounding communities or be receiving treatment at the Upstate Cancer Center in Verona or Oneida/Roswell Cancer Center. The application may be filled out by the person in treatment or by a family member.

Date of Application: _____

Referral to Application (how did you hear about Jessica's Heroes Foundation):

____ Friend: (*please write friend's name here*) _____

____ Facebook

____ Event: (*please write event here*) _____

____ Other: (*please write place or person whom referred you here*)

Applicant Name (*First and Last*): _____

Residential address of patient:_____

City: _____ **State:** _____ **Zip Code:** _____

Patient Phone #: _____ Patient Email: _____

Contact name for family member that is assisting in the application:

_____

Family member Phone #: _____ Family member Email:_____

Are you currently being treated? _____When were you diagnosed?_____

Name of medical provider/hospital?

_____

Jessica's Heroes Foundation recognizes how stressful your battle with cancer can be. We are here to help ease your stress in a small but caring way. It may not seem like much but this will allow you not to worry for a moment in time.

Please choose how we can help you during this time, from the suggested items listed below or choose other for us to help you another way (Based on available funding, we are able to give up to $500 per applicant per year.) Check all that apply.

_____ Groceries _____ Gas Card _____ Health Insurance Assistance

_____ Prescriptions/Co-pays Other_____

I, _____ (*applicant's name*) understand that Jessica's

Heroes Foundation will keep any information provided in extreme confidence, at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or my family members.

This form is strictly for the purpose of determining my eligibility for assistance I am seeking.

All information compiled within this application is honest and completed to the best of my ability, based on true and accurate information.

Signature Information of Applicant:

Applicant Signature: _____Date: _____

Applicant Printed Name: _____

In case applicant is unable to fill out form, please indicate family member's information:

Name of Family Member Applying for Applicant:

_____

Relationship of Family Member:

_____

Reason Applicant is unable to apply:

_____

Please return this completed form to:
Jessica's Heroes Foundation, Inc.
126 Washington Ave.
Oneida, NY 13421

OR Email completed, signed form to: info@jessicasheroesfoundation.com

Completion of this application does not indicate approval. The Jessica's Heroes Foundation will notify you regarding the outcome. All documents must be completed and approved to be reviewed for assistance.

The Jessica's Heroes Foundation Patient Aid Fund would not be possible without generous donations from our sponsors and individual supporters, taking part in our fundraising events and their thoughtful donations.

Please see our Resources Page on our website for other additional information and help from other organizations.

www.jessicasheroesfoundation.com