



We believe that giving a little bit of happiness and joy can help ease the stress of those that are battling cancer.

Financial Assistance Application Form.

This form is a patient application during treatment or hospice care and live/reside in the city of Oneida or surrounding communities. It can be filled out by the person in treatment or 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? _____

We, Jessica's Heroes recognize how stressful your battle 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 funding we are able to give up to \$200 per applicant per year).

_____ Dinner from a local restaurant

_____ Nail or salon service

_____ Hair or barber shop gift certificate

_____ Groceries

_____ Cleaning Service

_____ Gas Card

_____ Prescription

_____ Health Insurance Assistance

_____ Other



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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
117 E. Railroad St.
Oneida, NY 13421

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 Fund would not be possible without generous donations from our sponsors and individuals taking part in our events or their donations.