

# **APPLICATION FOR FINANCIAL ASSISTANCE**

\*\*MUST BE A MILLE LACS COUNTY RESIDENT TO APPLY

### PATIENT INFORMATION

| First & Last Name:  |           | DOB:                               |
|---|-----------|------------------------------------|
| Phone #:  | Email:    | :                                  |
| Physical Address:   |           |                                    |
| Mailing Address:  |           |                                    |
| **THE FOLLOWING SECTIONS ARE TO BE COMP<br>OR SOCIAL  |           |                                    |
| PERSON COMPLETING FORM  |           |                                    |
| First & Last Name:  |           | Title:                             |
| Phone Number:   |           |                                    |
| Relationship to Patient (Circle One): Doctor  | Nurse     | e Social Worker                    |
| MEDICAL INFORMATION   |           |                                    |
| Date of Diagnosis:  |           |                                    |
| Type of Cancer/Diagnosis:   |           |                                    |
| The applicant <u>MUST</u> be receiving one of the followin complete additional questions)                                   | g treatme | ents to be eligible (check one and |
| <ul> <li>Chemo (IV or Oral) – Frequency:</li> <li>Radiation – Frequency:</li> <li>Hospice Care – Name of Agency:</li> </ul> |           | Maintenance: Y / N                 |
| HEALTH CARE PROFESSIONAL INFORMATION  |           |                                    |
| Doctor's Name:  |           |                                    |
| Phone #:  | Fax #:    | :                                  |
| Hospital/Clinic:  |           |                                    |
| Address:  |           |                                    |

## PATIENT RELEASE

I declare the information on this application is true and correct to the best of my knowledge. I understand that each application is reviewed on a case-by-case basis, and the final decision will be made by Kick Cancer to the Curb of Mille Lacs County. I hereby give my permission that this application and all information offered can be provided to Kick Cancer to the Curb of Mille Lacs County and discussed with my healthcare professional. I understand that all information reviewed is confidential.

Applicant Signature:

Date of Signature:

# \*\*ONCE COMPLETED, PLEASE HAVE YOUR HEALTHCARE PROVIDER SUBMIT THIS FORM VIA EMAIL TO: <u>kccmillelacs@outlook.com</u>

### ADDITIONAL INFORMATION

Patients are eligible to receive one (1) grant, every six (6) months with a maximum of two (2) grants per calendar year. A new grant form is to be completed and submitted at the time of each grant request. Patients are to be a resident of Mille Lacs County, Minnesota to be eligible.

Kick Cancer to the Curb of Mille Lacs County is a nonprofit working to provide a monetary opportunity for residents of Mille Lacs County going through cancer. Brought forth by the incredible generosity of our donors and volunteers.