Completed application can be emailed or sent with the supporting documentation to:

The Pennies for Penny Foundation
270 SE Totten Shores Drive, Shelton WA 98584
Jingram.president@thepenniesforpennyfoundation.org

APPLICATION

Section A

NAME LAST, FIRST, MIDDLE (Claimant)	RECIPIENT NAME IF DIFFERENT	GENDER

DOB	COUNTY OF RESIDENCE	EMAIL ADDRESS

ADDRESS	CITY	STATE	ZIP

MAILING ADDRESS IF DIFFERENT

VIDEOPHONE IP	HOME PHONE	CELL	MARRIED STATUS	NUMBER OF DEPENDENTS

LIVING ARRANGEMENTS	BRIEFLY DESCRIBE YOUR CONDITIONS	CANCER MEDICATION CURRENTLY TAKING

LIST YOUR PHYSICIANS AND OR SPECIALISTS INVOLVED WITH YOUR TREATMENT:

NAME	ADDRESS

HEALTH CARE ADVOCATE NAME	

FINANCIAL STATEMENT (CLAIMANT AND/OR RECIPIENT)

Section B

MODIFIED ADJUSTED GROSS INCOME (Simplified Financial Statement)

Complete if you have your most recent tax return:		**Complete if you do NOT have your most recent tax return:**	
1. Adjusted Gross Income (from 1040: Line 8b)	$	1. Wage, tips, and/or salary for the most recent month (before taxes are withheld)	$
2. Tax exempt interest (Form 1040: line 2a) and non-taxable Socials Security, retirement or survivor benefits (Line 5a on Form 1040)	$	2. Self-employment income (after paying any business-related expenses)	$
Modified Adjusted Gross Income (annual basis)	$	3. Any other income received (e.g., unemployment benefits, alimony,child support, retirement benefits, interest income, capital gains, dividends)	$
If your Modified Adjusted Gross Income (MAGI) exceeds the limits in the table below please continue to fill out section XX Through XX.		4. Any deductions (e.g., alimony paid, tuition and fees paid for yourself, contributions to a HAS account)	$
[redacted]		Modified Adjusted Gross Income (monthly Basis)	$

Income	Individual	Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	Family of 7	Family of 8
Monthly	$3,349	$4,529	$5,709	$6,890	$8,070	$8,895	$10,431	$11,612
Annual	$40,186	$54,350	$68,515	$82,680	$96,845	$111,010	$125,174	$139,339

Section B

Actual Monthly Liabilities

1. Rent/Mortgage Payments	$	
2. Property Taxes	$	
3. Utilities, telephone, etc.	$	
4. Insurance payments; specify type and amount	Auto Insurance	$
		$
		$

5. Credit or charge accounts; specify	

Creditor/Loan	Total Owed	Monthly Minimum
	$	$
	$	$
	$	$

6. Loan payments; specify	

Creditor/Loan	Total Owed	Monthly Minimum
	$	$
	$	$
	$	$
	$	$

7. Medical expenses;	

Provider	Total Owed	Monthly Minimum
	$	$
	$	$
	$	$
	$	$

8. On-going disability-related expenses (attendant, therapy, prescriptions, equipment, etc.)	+$
9. Transportation expenses	+$
10. Vehicle License(s) (per month)	+$
11. Food	+$
12. Clothing	+$
13. Other; specify	+$
Actual Monthly Liabilities	Total $

I understand this information is confidential and only used to verify eligibility to receive funds from the Pennies for Penny Foundation to assist in covering some or all of my or my dependents “out of pocket” expense for medication due to my or my dependents cancer treatment.

I swear under penalty of perjury that all information provided and entered on this form is true and constitutes a full disclosure of my and my dependents income and liabilities. I understand my responsibility to immediately report to the Foundation any changes in our financial status. I further understand that the Foundation may deny or suspend service if this information provided by me is found to be inaccurate or incomplete.

A copy of the most recent tax return I have filed or on which I was claimed as a dependent is included if available and appropriate. I will furnish other documentation of my financial status upon request.

Should approval of funding be granted by PFPF, claimant(s) must agree to pay out of pocket expenses at time of service and submit receipts to PFPF in order to be reimbursed up to the approved amount.

_____ _____

Signature Patient Date Signature Legal Guardian Date

Section C (FOUNDATION USE ONLY)		
DATE RECEIVED	/ /	**MAIL OR WEBSITE**
DATE REVIEWED	/ /	**APPROVAL Y or N**
AMOUNT APPROVED DATE:	**$**	**MONTHLY OR IN TOTAL**
TO BE PAID TO:		
ADDRESS		
COMMENTS:		