THE FLY FOUNDATION

FINANCIAL LIFT FOR YOUNG ADULTS WITH CANCER

Please return to info@theflyfoundation.org

PATIENT INFORMATION:

Today's date:

First Name: _____ Last Name: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Email address: _____ US Citizen: Yes: _____ No: _____

Date of Birth: _____ Male: _____ Female: _____

DIAGNOSIS:

Primary Cancer: _____ Stage: _____ Date of diagnosis: _____

New: _____ Recurring: _____ Is patient actively being treated? Yes: _____ No: _____

TREATMENT:

Chemotherapy _____ Radiation _____ Surgery _____ Hormonal _____ Palliative Care _____

Bone marrow/stem cell transplant _____ Other _____

* HEALTH CARE PROFESSIONAL INFORMATION:

MD Name: _____ Hospital/Clinic: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

** Please include official diagnosis verification letter from physician, with this application.*

HEALTH INSURANCE INFORMATION:

Does patient have health insurance coverage? Yes _____ No _____

If yes, please indicate all that apply:

Private _____ Medicaid _____ Medicare _____ Medicare plus Medigap _____ Charity care _____

VA Program _____ Other _____

Are patient's prescription drugs covered by insurance? Yes _____ No _____ Co-pay _____

HOUSEHOLD FINANCIAL INFORMATION:

Is patient currently employed*? Yes_____No_____

Spouse's Name: _____ Is spouse currently employed*? Yes_____No_____

(if applicable)

Other dependents: _____ _____ _____

(please list all) _____ _____ _____

_____ _____ _____

Source of Patient Income *(please check all that apply)*

Social Security _____ Salary _____ Pension _____ Unemployment _____ SSD (disability) _____SSI _____

Public Assistance _____ Short-term Disability _____ Long Term Disability _____ Spouse's Income _____

Personal Income _____ Family Support _____ Friends _____ Other_____

If other, please list: _____

Total Annual Household income: $ _____

** Please include latest pay stubs, with this application.*

FAMILY ASSETS: *(please provide Totals for all accounts that apply)*

Checking Account: $_____ Savings Account: $_____ CDs: $_____

Money Market: $_____ Stocks/Bonds: $_____ IRA/401K/403: $_____

Other Assets: $_____

Total Family Assets: $_____

FINANCIAL OBLIGATIONS, FOR WHICH PATIENT IS REQUESTING ASSISTANCE:

(please provide Totals for all that apply)

Mortgage/Rent: $_____ Utilities: $_____ Co-pays: $_____

Medications: $_____ Other: Expense_____ $_____

Expense_____ $_____

Expense_____ $_____

**** Please include receipts, statements for any requested support (e.g.: Mortgage Statement Receipt, etc)***

APPLICATION WILL NOT BE PROCESSED, WITHOUT COPY OF DRIVER'S LICENSE ATTACHED AND ADDITIONAL INFORMATION, AS REQUIRED ABOVE.

BY SIGNING THIS APPLICATION, YOU CONFIRM THAT ALL INFORMATION DISCLOSED HERE IS CURRENT AND ACCURATE, TO THE BEST OF YOUR KNOWLEDGE. YOU ALSO AGREE THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS SUBJECT TO VERIFICATION, WHICH MAY ALSO INCLUDE A CRIMINAL HISTORY BACKGROUND CHECK.

Print Name: _____Date: _____

I CERTIFY THAT THE FOLLOWING ATTACHMENTS ARE INCLUDED, WITH MY APPLICATION:

Please check all that apply

_____ ***Driver's License***

_____ ***Latest pay stubs***

_____ ***Physician diagnosis verification letter***

_____ ***Receipts, statements for any requested support (e.g.: Mortgage Statement)***

Signature: _____

Please include an additional narrative of your circumstances (in the space below) which you would like The FLY Foundation Board of Directors to consider, when determining grant eligibility.

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How did you hear about us?

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