# Application for Support

**PROCEDURES:**

1. Pages 2 and 4 need to be completed by the patient or parent/guardian, including a signature.

   *** Please note – Tricia's Troops Cancer Connection has a geographical service area of Waukesha County and our bordering counties. If the patient does not live in the following counties, we cannot approve support: Dodge, Jefferson, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha.*

2. The MEDICAL INFORMATION on page 3 needs to be completed by a medical professional at the patient's treatment facility.

3. Please return the completed paperwork to the address listed below. Applications may also be scanned and e-mailed to **support@triciastroops.org**.

4. All pages and all sections of the application must be completed in order to receive consideration.

*Support will be awarded without regard to race, national origin, gender or sexual orientation. Guidelines and criteria for support will be provided upon request or are available on our website.*

**Tricia's Troops Cancer Connection**
2410 Milwaukee St., Suite C
Delafield, WI  53018
E-mail: support@triciastroops.org
(262) 303-4034

**www.triciastroops.org**

# Financial Assistance Application for Support

## PATIENT INFORMATION

Today's Date:________________

Name:_________________________________ Date of Birth: ________________

Street Address: ____________________________________________________________

City: ______________________ County:__________________ Zip Code:______________

Phone: ____________________ Email Address: ___________________________________

Gender:______ Race:______ U.S. Citizen? ______Language Spoken:__________________

*If patient is a minor (under 18)* ***OR*** *unable to speak on the phone* ***OR*** *does not speak English, please provide contact information for the person authorized by the patient to speak with us about this application.*

Name _____________________ Phone _________________ Relationship ____________

## FINANCIAL INFORMATION

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Disability ☐Student

Insurance Status: ☐Private Insurance ☐Medicare ☐Medicaid ☐VA Benefits ☐Uninsured

Number of People Living in Household:____ Household's Total Annual Income: _______

Names/Ages of Household Residents: __________________________________________

***Proof of income MUST be provided with this application. Acceptable proof of income includes:***

*• The first two pages of federal income tax return (You may blacken out social security number)*

***- OR -***

*• A copy of your most recent pay stub, unemployment check or SSI, SSD or public assistance benefit notification*

## REQUEST FOR FINANCIAL ASSISTANCE

**Assistance is requested in relation to:** *(check your must urgent needs)*

☐Fuel/Transportation ☐Groceries/Meals ☐Utilities ☐Rent/Mortgage

☐Equipment/Products/Supplies ☐Home Cleaning/Lawn Care ☐Dental

☐Child Care ☐In-Home Caregiving ☐Other: ________________________________

***Please note: We do NOT provide financial assistance for medical bills, treatment expenses, co-pays or deductibles***

## I WOULD LIKE TO LEARN MORE ABOUT OTHER FREE SUPPORT SERVICES *(OPTIONAL)*

☐Wig Bank Program ☐Support Groups ☐Wellness Activities (Yoga, workouts, nutrition)

## AVAILABILITY FOR IN-PERSON PROGRAMMING AT TRICIA'S TROOPS *(OPTIONAL)*

☐Weekday Mornings ☐Weekday Afternooons ☐ Weekday Evenings

**Release of Information:** By signing below, I authorize Tricia's Troops Cancer Connection to obtain and discuss information related to this application with my physician and/or other treatment providers for the sole purpose of verifying my eligibility for financial assistance. All information related to this application will be kept strictly confidential and will not be shared with other parties.

**Patient or Guardian Signature:** ______________________________ **Date:** ____________

***This section to be completed by a health professional at your treatment facility***

Patient's Name: ______________________________________

Date of Diagnosis: ____________ Primary Cancer: ____________ Current Stage: ______

Is the patient above currently under the care of your facility for cancer treatment? ☐ Yes ☐ No

*(Tricia's Troops may require documentation of a diagnostic or monitoring test proving evidence of disease within the past 6 months).*

**Current Treatment:**

☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Hospice/Palliative Care

Frequency of Treatment: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Physician Name: ______________________________________

Hospital/Clinic Name: ____________________________________

Street Address: __________________________ City: ____________ Zip: __________

Name of Person Completing This Form: *(If not the physician)* __________________________

Relationship to Patient: ☐ Physician ☐ Nurse ☐ Social Worker ☐ Other ____________

Phone: _________________ Email Address: ________________________________

On a scale of 1-5, how would you rate the urgency level for this patient's need for assistance:

*(1 = would be help; 5 = extremely urgent)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

If you are aware of a time-sensitive urgency related to this application, please describe:

______________________________________________________________________

______________________________________________________________________

Has this patient received support from Tricia's Troops in the past? ☐ Yes ☐ No ☐ Unsure

## DESCRIPTION OF NEED

***** THIS SECTION MUST BE COMPLETED TO BE ELIGIBLE FOR SUPPORT *****

*Use this space (or attach a separate sheet) to describe why you are requesting assistance from Tricia's Troops Cancer Connection. If your request is time-sensitive, please explain any deadlines. Please note that we receive more applications for support than we can fund, so be sure to include any details regarding your unique situation that might be helpful when reviewing your application.*

________________________________________

________________________________________

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## MAY WE SHARE YOUR STORY?

☐ **YES** – I permit Tricia's Troops, Inc. to share elements of my story *(while protecting my identity)* on their website, social media pages or other public relations materials to help promote the impact of their mission and touch the lives of more local cancer fighters and survivors.

☐ **NO** – My story may be shared with the management team at Tricia's Troops, Inc. only.

**WOULD YOU LIKE YOUR NAME TO BE ADDED TO OUR PRAYER LIST?** ☐ Yes ☐ No

## SIGNATURE

*I attest that all information contained in this application is correct and complete to the best of my knowledge. I understand that submission of this application does not guarantee funding. I further understand that Tricia's Troops, Inc. will not make monetary payments directly to individuals. If financial assistance is awarded, funds will go directly to the vendor of goods/services provided.*

Patient/Guardian Signature ______________________________ Date ______________

## FOR INTERNAL USE ONLY

**Status of assistance request:** ☐ Approved ☐ Denied

Date Approved: ______________ Amount Approved: __________

Vendor(s) & Amount of Distribution ______________________________

Method of Disbursement: ☐ Mail ☐ Cancer Center Employee ☐ Personal Delivery ☐ Other

Comments: ______________________________

________________________________________