



SALARY/WAGES: \_\_\_\_\_ (Proof of income should be for the previous 30 day period and should be for all who contribute to or are dependent on the cancer patient's household income.)

- One month consecutive documentation including pay stubs
- Pay stub with year-to-date income
- Letter on company letterhead
- Notarized statement from employer
- Bank statement

MEDICAL EXPENSES: (Include unpaid expenses not subject to reimbursement by any other public or private source.)

- Medical insurance
- Doctors visits
- Treatments
- Medicine
- Medical supplies

HOUSEHOLD EXPENSES:

- Rent/mortgage
- Utilities- electric, gas, water, phone.
- Other monthly expenses

SELF-EMPLOYMENT INCOME:

- 1099 form including Schedule C from the most recent tax return
- Copy of most recent check or check stub

SOCIAL SECURITY RETIREMENT: \_\_\_\_\_

- Benefit statement for current year
- Copy of most recent bank statement showing direct deposit
- Copy of most recent check or check stub

SUPPLEMENTAL SECURITY INCOME: \_\_\_\_\_

- Benefit statement for current year
- Copy of most recent bank statement showing direct deposit
- Copy of most recent check or check stub

SOCIAL SECURITY DISABILITY: \_\_\_\_\_

- Benefit statement for current year
- Copy of most recent bank statement showing direct deposit
- Copy of most recent check or check stub

UNEMPLOYMENT: \_\_\_\_\_

- Unemployment award letter on company letterhead indicating the period covered
- Copy of most recent unemployment check or check stub

VETERANS BENEFITS; \_\_\_\_\_

- Benefit statement of current year
- Copy of most recent bank statement showing direct deposit
- Copy of most recent check
- Check stub

ALIMONY/CHILD SUPPORT: \_\_\_\_\_

- Court award letter indicating amount and time period covered
- Child Support Enforcement Agency letter
- Letter from attorney stating amount and time period covered
- Copy of one month's check
- Bank statement with amount indicated

PENSION/RETIREMENT: \_\_\_\_\_

- Benefit statement for current year
- Copy of most recent bank statement showing direct deposit
- Copy of most recent check
- Check stub

OTHER: \_\_\_\_\_

- Benefits statement
- Award letter
- Bank statement from payer/source
- Copy of checks
- Judgment statements

**INSURANCE INFORMATION:**

MEDICARE: Is the cancer patient eligible for Medicare or Medicaid?

Y \_\_\_ N \_\_\_

Have you ever been turned down for Medicare or Medicaid assistance?  
Y\_\_N\_\_ If yes, please provide a copy of the denial letter.

Do you have any kind of medical insurance? Y\_\_ N\_\_  
If yes, what kind? (Check all that apply and amount)

- Medicare A
- Medicare B
- Medicaid
- Veterans
- Private (Specify company) \_\_\_\_\_

Do you receive prescription drug coverage or discount assistance of any kind? Y\_\_ N\_\_ Please specify what kind. \_\_\_\_\_

By my signature, I certify that all the information on the application is correct and complete. I do not qualify for Medicare or Medicaid, and I do not have sufficient financial resources to pay for medical treatments or medications related to my cancer.

\_\_\_\_\_ Date \_\_\_\_\_  
**Cancer patient signature**

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. To the best of my knowledge, the cancer patient has insufficient funds to be able to receive medical treatment or medications or pay bills resulting from high costs of medical treatments and medications.

\_\_\_\_\_ Date \_\_\_\_\_  
**Witness signature**

Application must include a copy of current tax return.

After completing application please send to the following address:

Angel Fund Foundation, Inc.  
P.O. Box 6232  
Texarkana, TX 75505

Your application will be processed and you will be contacted if any more information is required. You will receive written notice of approval or disapproval within thirty days.

