

ANGEL FUND FOUNDATION

(Please use dark ink or type)

Note: This application is for assistance with medical expenses for cancer patients who meet the set criteria listed on the separate page.

DATE _____ REFERRED BY _____

NAME _____
First Name Middle Name Last Name

ADDRESS _____
Street
City State Zip Code

PHONE _____ CELL PHONE _____

BIRTHDATE _____ GENDER ___M___F US CITIZEN ___Y___N

LEGALLY DISABLED ___Y___N MARITAL STATUS _____

CONTACT PERSON IF OTHER THAN SELF _____ PHONE # _____

CANCER DIAGNOSIS _____

PHYSICIANS' NAME _____ OFFICE PHONE # _____

PLACE OF TREATMENTS (if applicable): _____

Please give a brief history of your cancer illness (screening, diagnosis, treatments, etc.) and why you need assistance from Angel Fund Foundation:

MEDICAL EXPENSES:

Please list all unpaid medical expenses related to your cancer that you are unable to pay and are not covered for reimbursement by any government or private sources. Include doctor visits, medications, treatments, procedures, medical supplies, etc. Please include copies of these medical bills for which you need financial assistance. (If approved, AFF pays directly to the medical provider or center.)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

INSURANCE INFORMATION:

MEDICARE/MEDICAID: 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 the applies)

- Medicare A
- Medicare B
- Medicaid
- Veterans
- Private (Specify company) _____

Do you have any prescription drug coverage or discount assistance of any kind? Y ___ N ___

If yes, please specify what kind. _____

FINANCIAL INFORMATION:

(Any of the following documents listed are acceptable as proof)

HOUSEHOLD SIZE _____ (include number of people who contribute to or are dependent on cancer patient's household income.)

HOUSEHOLD INCOME:

(Please select any options below that apply to you)

_____ **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 patients' household income.) Choose one of these options as proof of income.

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

_____ **SELF –EMPLOYMENT INCOME:**

- ___ 1099 Form including Schedule C from the most recent tax return
- ___ Copy of the most recent paycheck or paycheck 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**

- ___ Pending notification after applied
- ___ Benefit statement for current year
- ___ Copy of most recent bank statement showing direct deposit
- ___ Copy of most recent check or check stub

_____ **UNEMPLOYMENT BENEFITS**

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

_____ **VETERAN BENEFITS**

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

___ PENSION/RETIREMENT

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

___ OTHER

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

By my signature, I certify that all the information on the application is correct and complete. 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 medical bills resulting from high costs of medical treatments and medications.

_____ Date _____

Witness

Application must include a copy of a current tax return.

After completing the application, please mail to the following address:

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

or you can FAX it to 866-824-4930. If you have any questions, call 903-791-0349.

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.

Angel Fund Distribution Guidelines

We are a small organization with limited funds, but we are willing to work with you and all organizations as long as funds are available.

1. We only pay bills submitted and approved with the application.
2. We do not pay outstanding bills before diagnosis or bills for the diagnosis. Approval is based on available funds.
3. When the approved funds run out you can reapply, but these might not be accepted. Approval is based on available funds.
4. These guidelines must be signed and dated by the applicant before the application can be processed.

Name: _____

Date Signed: _____ **Date of Diagnosis:** _____