



HOPE FOR THE JOURNEY/
COMMUNITY FOUNDATION OF THE OZARKS (CFO)
APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or on-going consequences of treatment related to cancer. Application for assistance will be individually evaluated by a committee after completion of this form and verification from your health care provider concerning your cancer status. Preference is given to those residing in Greene, Christian, Taney, Stone, Berry, Lawrence, and Newton counties. Maximum amount available is \$1,000.00.

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____

Email: _____ County: _____

Phone#: _____ If cell may we text applicant: _____ Yes _____ No

Employer (if applicable): _____

Medical Diagnosis: _____

Physician(s) Name and Phone Number: _____

Unless you're an OHA patient, please attach a physician's letter which confirms your diagnosis.

Amount Requested: \$ _____

Please state the intended use for the funds requested:

Other Agencies which you are currently receiving funds:

What kinds of services are being provided:

Health Coverage: _____ No _____ Yes

If yes, circle type: Personal Policy, Employer Policy, Medicare, Medicaid

Financial Information: (For office use only. This is confidential information and will not be shared)

Monthly Income

Monthly Expenses

Employment: Patient: _____
 Spouse: _____
 Other: _____

Retirement: Social Security: _____
 VA Pension: _____
 Employee Pension: _____

Other Income: Alimony: _____
 Child Support: _____
 Investments: _____
 Public Assistance: _____
 Workman’s Comp: _____
 Unemployment: _____
 Disability: _____
 Insurance: _____

Rent/Mortgage: _____
 Utilities: _____
 Food: _____

Insurance Health: _____
 Insurance Home: _____
 Insurance Car: _____

Medical: _____
 Auto Payment: _____
 Credit Card Debt: _____
 Savings: _____
 Other Expenses: _____

Tell us about your financial situation:

By signing this form you are agreeing that the Community Foundation of the Ozarks can receive information verifying your cancer status. I hereby certify that I have been diagnosed with cancer and require financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used for eligibility determination. You may be asked to discuss benefits of assistance.

_____ Date

_____ Patient Signature

PLEASE RETURN ALONG WITH LETTER WHICH CONFIRMS DIAGNOSIS TO:
Community Foundation of the Ozarks, Attn: Ellen Neville-Verdugo, at PO Box 8960,
Springfield, MO 65801

CALL: 417-864-6199 for application questions or **E-Mail:** eneville-verdugo@cfozarks.org