

OneRunTogether Inc., Patient Medical Grant Application

PATIENT INFORMATION (Please Print Clearly)

First Name: _____ Last Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: Home () _____ Work () _____ Cell () _____ Email Address: _____ Date of Birth: _____
If Patient is a minor (under 18), Name of Parent and/or Guardian: _____
 Male Female _____ Single _____ Married _____ Widow(er)
The Patient is: A Citizen of the U.S. Not a Citizen of the U.S. Ethnicity: White African American Latino Asian Other

MEDICAL INFORMATION (This Section Must Be Completed By Nurse, Doctor, Social Worker or Hospital ACS Patient Navigator Only)

PLEASE COMPLETE ALL FIELDS

Date of Definite Cancer Diagnosis: _____ Primary Cancer: _____ Stage: _____
 New Diagnosis Recurrence Is patient in active treatment: YES NO
If Not in active treatment, indicate frequency of follow up: Yearly Every Six Months Other _____
 Chemotherapy Radiation Surgery Hormonal Palliative Care Bone Marrow/Stem Cell Transplant

Health Care Professional Information (Print Please)

Medical Physician: _____ Hospital/Clinic: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: () _____ Facsimile () _____ Email Address: _____

NAME AND TITLE OF PERSON COMPLETING THIS FORM (Please Print Clearly)

Name: _____ Phone Number: () _____ Email Address: _____ Your Relationship to Person
Applying For Assistance: Physician Nurse Social Worker ACS Hospital Navigator Other _____
Signature of Medical Professional: _____ Date: _____

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HEALTH INSURANCE INFORMATION

Does the Patient Have Health Insurance: YES NO

If Yes, Please Indicate Type of Insurance (Check All That Apply):

Private Insurance Medicaid Medicare Plus Medigap Charity Care VA Program Other _____

Are Prescription Drugs Covered YES NO

HOUSEHOLD FINANCIAL INFORMATION

Is Patient Currently Employed: YES NO

Is The Patient's Spouse Currently Employed: YES NO

Number of People in Household: _____

FAMILY INCOME SOURCES: (Please Check all that Apply)

Social Security Salary Pension Unemployment Retirement Public Assistance
 SSD (Disability) SSI Family/ Friends Short Term Disability Other _____

Patient's Total Annual Income: _____ Patient's Spouse Total Annual Income: _____

Family Assets (Provide Total Amount in All Accounts That Apply):

Checking: _____ Money Market: _____ Savings: _____ CD: _____ IRA/403b/401k _____

Stocks & Bonds: _____ Other: _____ Total Family Assets: _____

FINANCIAL ASSISTANCE NEEDS (Please Check All That Apply)

I Need Assistance With The Following Cancer-Related Expenses:

Transportation Child Care Home Care Pain Medication Lymphedema Supplies Other: _____

Signature: _____

Date: _____

Please be advised that our funds are limited and based on availability. Patients must meet OneRunTogether Inc.'s eligibility requirements. Our grants **are** for living expenses such as rent, mortgages, utility payments and/or food, and we **do** provide grants for medical bills and/or insurance co-payments. The function and final use of this grant will be determined by the OneRunTogether Board of Directors.

Please forward this form to OneRunTogether Inc., at 135 Schoolhouse Lane, Coatesville, PA 19320 or E-mail it to Vmurphy@OneRunTogether.org

OneRunTogether Inc., will review the information and contact the person requesting the financial assistance. All information is strictly confidential and is for OneRunTogether Inc., use only. INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED