Silver Lining Cancer Fund
Financial Assistance Application

Patient's Name: _____ SSN: _____

Address: _____ DOB: / /

_____ Married___ Single___ Widow(er)___ Divorced___
City State Zip

Home Phone: _____
Employer: _____ Work Phone: _____
Name Address

Spouse's Employer: _____ Spouse's Name: _____
Name Address

Spouse/Parent SSN: _____ No. of Dependents _____

Physician's Name: _____ Cancer Diagnosis: _____

Social Worker: _____ Receiving Active Treatment? Y N

Treatment Facility: _____

TO WHAT EXTENT DO THE FOLLOWING COVER THE MEDICAL EXPENSES OF APPLICANT?			
Services to be covered:	**Inpatient**	**Outpatient**	**Medications**
Medicare			
Medicaid (public assist.)			
Employer Insurance Name of Ins. Co.			
Major Medical Name of Ins. Co.			
Veteran's Assistance			
Private Insurance Name of Co.			

Medications: _____

SUMMARY OF MONTHLY INCOME AND EXPENSES			
Source of Income	**Amount**	**Source of Expenses**	**Amount**
Salary of patient	$	Mortgage or Rent	$
Salary of Spouse	$	Food	$
Salary of other individuals at home	$	Utilities (gas, electric, water, trash, cable)	$
Social Security	$	Insurance Premiums	$
Social Security Disability	$	Property Taxes	$
Social Security SSI	$	Avg. Monthly Medical (past 6 months)	$
Unemployment Compensation	$	Other –Specify:	$
Pension	$		$
Income from interest and investments	$		$
Other – specify	$		$
Total Income:	$	Total Expenses:	$

_____ _____
Patient or Family Member Signature Date

Return to: Silver Lining Cancer Fund, Inc. P.O. Box 401, Canfield, OH 44406