Silver Lining Cancer Fund
Financial Assistance Application

Patient's Name: _____

Address: _____

_____
City State Zip

Employer: _____
Name Address

Spouse's Employer: _____
Name Address

Spouse/Parent SSN: _____

Physician's Name: _____

Social Worker: _____

Treatment Facility: _____

SSN: _____

DOB: _____ / _____ / _____

Married__ Single__ Widow(er)__ Divorced__

Home Phone: _____

Work Phone: _____

Spouse's Name: _____

No. of Dependents: _____

Cancer Diagnosis: _____

Receiving Active Treatment? Y N

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 house	$	Utilities (gas, electric, water, trash, cable)	$
Social Security	$	Insurance Premiums	$
Social Security Disability	$	Property Taxes	$
Social Security SSI	$	Ave. Monthly Medical (past 6 months)	$
Unemployment Compensation	$	Other - Specify:	$
Pension	$		$
Income from Interest and Investments	$		$
Other - Specify	$		$
TOTAL INCOME:	**$**	**TOTAL INCOME:**	**$**

_____ _____
Patient or Family Member Signature Date

RETURN TO: Silver Lining Cancer Fund, Inc., P.O. Box 401, Canfield, OH 444006

PLEASE ASK YOUR DOCTOR, NURSE, OR SOCIAL WORKER TO DOCUMENT YOUR TREATMENT PLAN AND INCLUDE IT WITH THIS FORM. PATIENTS MUST BE UNDER GOING ACTIVE TREATMENT OF CHEMOTHERAPY OR RADIATION TO RECEIVE ASSISTANCE. THANK YOU.