



Cancer Alliance of Naples, Inc.
733 Fourth Avenue North
Naples, FL 34102
Telephone: (239) 437-4673 Fax: (239) 436-5476

Date \_\_\_/\_\_\_/\_\_\_

CAN Application for Beneficial Aid

Applicant Name
Address 1
Address 2
City, State, Zip
Phone (home) (cell)
Email Address
Date of Birth SS#
Drivers License # STATE Expiration

NOTE: CAN is required to fill out the following information ( in italics) in order to apply for grants from federal and other agencies. Please circle the appropriate answers to the following questions:

Age Group: Infants-Under 5 5-12 years 13-17 years 18-29 years 30-64 years 65 plus years
Gender: Male Female
Ethnic Background: White Black Hispanic Other ethnic minority
Income Level: Below official poverty level At or near poverty level Middle income

Diagnosis Date Type Of Cancer Stage

Treating Physician ph#

Do you have Health Insurance?

If yes, please complete the following:

Insurance Company Name

Policy and Group # Contact Name Phone

Employer Phone Contact

Spouse Name Children (living at home) and ages



**Credit Cards:**      Company Name                      Balance Owed  
                                  \_\_\_\_\_ \$ \_\_\_\_\_  
                                  \_\_\_\_\_  
                                  \_\_\_\_\_

**Other:**                                      Monthly Payment                      Due Date  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RELEASE OF FINANCIAL INFORMATION:**

You have asked the Cancer Alliance of Naples, Inc. (CAN) for financial assistance. By signing this three-page application, you hereby acknowledge that to the best of your knowledge all of the information included in this application is correct. You agree by signing this document that CAN has your authorization to make any and all inquiries to verify any and all of the financial information in this application. This may include obtaining any and all reports in the files of consumer credit reporting companies regarding the undersigned. You hereby authorize CAN, and any of its officers, or executive director or office manager to request any information regarding your credit and your assets. The undersigned agrees that this application and statement is the property of the Cancer Alliance of Naples, Inc.

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

(If under 18, parent or legal guardian's signature) Relationship to Beneficiary minor \_\_\_\_\_

**Please attach copies of the following:**

- Proof of residency as having lived in Collier County for 1 (one) or more years (i.e. lease agreement, deed, tax return)**
- Copy of Driver's License or other photo ID**
- REMINDER: Give Physician's Verification Form to your oncologist to fill out. The doctor will fax the completed form back to CAN office: 239/436-5476. No financial assistance is possible without a physician's verification.**

**Please let us know how you learned about CAN:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\*\*\*\*\*

**For office use only:**

This document is signed in the presence of \_\_\_\_\_ who is either an officer, director, executive director, or office manager of CAN.

Signature \_\_\_\_\_ Position \_\_\_\_\_

Date accepted \_\_\_\_\_ File # \_\_\_\_\_ Declined/reason \_\_\_\_\_