

**Cancer Alliance of Naples, Inc.**  
733 Fourth Avenue North  
Naples, FL 34102

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

**CAN Application for Beneficial Aid**

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

Diagnosis Date \_\_\_\_\_ Type Of Cancer \_\_\_\_\_

Treating Physician \_\_\_\_\_ ph# \_\_\_\_\_

Do you have Health Insurance? \_\_\_\_\_

If yes, please complete the following:

Insurance Company Name \_\_\_\_\_

Policy and Group # \_\_\_\_\_ Contact Name \_\_\_\_\_ PH# \_\_\_\_\_

Spouse Name \_\_\_\_\_

Children (living at home) and ages \_\_\_\_\_

\_\_\_\_\_

Have you applied for:

? Medicaid When? \_\_\_\_\_ Approved? \_\_\_\_\_

? Food Stamps When? \_\_\_\_\_ Approved? \_\_\_\_\_

? SSI When? \_\_\_\_\_ Approved? \_\_\_\_\_

? Social Security Disability When? \_\_\_\_\_ Approved? \_\_\_\_\_

? Drug Compassion Program When? \_\_\_\_\_ Company Name \_\_\_\_\_ Approved? \_\_\_\_\_

Please list other organizations contacted regarding financial aid (Social Services, Catholic Charities, etc.)

Agency	Contact Person	Date of Contact	Benefits Rec'd

Employer \_\_\_\_\_ Employer ph# \_\_\_\_\_ Contact \_\_\_\_\_

Personal References	Relationship	Yrs Known	Ph#

Do you **RENT** or **OWN** (circle one) Monthly Payment \$ \_\_\_\_\_

Household Monthly Income \$ \_\_\_\_\_

Do you own a business? \_\_\_\_\_

If yes, please attach the business name, address and a copy of your latest quarterly or yearly tax return.

**Income Information**

Individual Monthly Income \$ \_\_\_\_\_  
 Retirement/Pension \$ \_\_\_\_\_  
 Interest and Dividends \$ \_\_\_\_\_

Spouse Monthly Income \$ \_\_\_\_\_  
 Child Support/Alimony \$ \_\_\_\_\_  
 Other Sources of Income \$ \_\_\_\_\_

	Yes	No	Balance
Do you own stocks or bonds?	_____	_____	\$ _____
Do you have a checking account?	_____	_____	\$ _____
Do you have a savings account?	_____	_____	\$ _____
Do you have a money market account?	_____	_____	\$ _____
Are you a member of a credit union?	_____	_____	\$ _____

**Monthly Expenses**

	Monthly Payment	Due Date
Rent/Mortgage	\$ _____	_____
Homeowner's Insurance	_____	_____
Health Insurance	_____	_____
Auto Loan(s)	_____	_____
Food	_____	_____
Utilities (electric, water, phone)	_____	_____
	_____	_____
	_____	_____

Credit Cards	Company Name	Balance Owed
	_____	\$ _____
	_____	_____
	_____	_____

Other	Monthly Payment	Due Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Past Due Debtors in YOUR Priority	Amount Due
_____	_____
_____	_____
_____	_____
_____	_____

Please attach copies of the following:

? Proof of residency for more than 1 (one) year (i.e. lease agreement, deed, or tax return)

I certify with my signature that to the best of my knowledge the financial information I have provided is complete and accurate. I understand that the information I have given is subject to verification by the Cancer Alliance of Naples. I also understand that I am responsible to inform CAN of any change in my financial status. I further understand that CAN is a privately funded organization and the final determination of qualification for financial assistance is by the governance of its board of directors.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**CAN Volunteer/Staff**

\_\_\_\_\_  
**Date**

**For Internal Office Use Only:**

Applicant: ? Approved ? Denied

Date \_\_\_\_\_

**Notes** \_\_\_\_\_

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

Please submit application to:  
**Cancer Alliance of Naples, Inc.**  
733 Fourth Avenue North  
Naples, FL 34102  
(239) 436-HOPE(4673)  
Fax-(239) 436-5476