Cancer Alliance of Naples
3384 Woods Edge Circle Suite # 102
Bonita Springs, FL 34134
Telephone: (239) 643-4673
Fax: (239) 643-4616

Date____/____/____

CAN Application for Beneficial Aid

Section 1: Patient Information

Applicant Name_____

Spouse/Caregivers Name _____

Children Living Home (Name and Ages) _____

Address _____

City, State, Zip_____

Phone (Home)_____ (Cell) _____

Email Address _____

Date of Birth_____

Driver's License #_____ State _____ Expiration _____

Landlord's Name _____ Phone _____

Landlord's Address_____

NOTE: *CAN is required to provide the following information (in italics) when applying for grants from government, private and other non-profit agencies. This data allows us to provide financial assistance to our beneficiaries. 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* ***Race:*** *White Black Other _____*
Ethnic Background:	*Hispanic Other Ethnic Minority _____*
Income Level:	*Below Poverty Level At Poverty Level Middle Income* ***Are you a Veteran?*** *Yes No*

Diagnosis Date_____ Type of Cancer_____ Stage _____

Treating Physician_____ Phone_____

Do you have Health Insurance? Yes or No (Please Circle)

If yes, Insurance Company Name _____

If you are in **Hospice** care, please list Agency _____
Caseworker_____ Phone_____

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

Agency	Contact Person	Date of Contact	Benefits Received

Personal References	Relationship	Years Known	Phone
_____	_____	_____	_____
_____	_____	_____	_____

Section 2: Financial Information

Have you applied for:

- ☐ Medicaid When? _____ Approved? _____
- ☐ Food Stamps When? _____ Approved? _____ Amount? _____
- ☐ SSI When? _____ Approved? _____ Amount? _____
- ☐ Social Security Disability When? _____ Approved? _____ Amount? _____
- ☐ Drug Compassion Program When? _____ Approved? _____ Amount? _____
- ☐ Cancer Alliance of Naples When? _____ Approved? _____ Amount? _____

Monthly Family Expenses	Amount	Family Assets	Amount
Rent/Mortgage	$	Checking	$
Phone	$	Savings	$
Electric	$	Money Market	$
Water	$	Stocks	$
Auto Loan	$	Bonds	$
Auto Insurance	$	Other (specify)	$
Gas Cost (per month)	$		
Food	$		
Health Insurance	$		
Medical Bills	$		
Credit Cards	$		
Other (specify)	$		
Monthly Expenses Total	**$**	**Family Assets Total**	**$**

Number of people in Household? _____ Pets? _____

Income Information:

Individual Monthly Income	$_____	Spouse Monthly Income	$_____
Retirement/Pension	$_____	Child Support/Alimony	$_____
Interest and Dividends	$_____	Other Sources of Income	$_____

Applicant Employer _____ Spouse Employer _____

Employer Contact Number _____ Spouse Employer Contact Number_____

Any additional property/land in your name? _____ Address _____

Section 3: Release of Financial Information

You have requested financial assistance from the Cancer Alliance of Naples, Inc. By signing this document, you hereby certify the information included is true and correct to the best of your knowledge. Your signature authorizes CAN to divulge your name and diagnosis for grant writing purposes and make any inquiries needed to confirm any disclosed financial information, including but not limited to obtaining credit reports as verification.

Payment is dependent upon availability of funds. Grants are awarded without regard to race, national origin, gender, or sexual orientation and may be suspended at any time due to unavailability of funds.

The undersigned agrees that this application is a true and correct statement and 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 Minor Beneficiary _____

Please attach copies of the following:

- **Proof of residency as having lived in Collier County or Lee County, for 1 (one) or more years (i.e. lease agreement, deed, tax return).**
- **Copy of Driver's License or other photo ID.**
- **Proof of Income.**
- **IMPORTANT: Give Physician's Verification Form to your oncologist to complete and sign. The doctor will fax the form back to the CAN office: 239/643-4616. 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 _____, an Officer, Director, Executive Director, or Office Manager of CAN.

Signature _____ Position _____

Date accepted _____ File # _____ Declined/Reason _____