ELLIS FUND / COMMUNITY FOUNDATION OF THE OZARKS (CFO)

APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or on going consequences of treatment related to cancer. Applications for assistance will be individually evaluated by a committee after completion of this form and verification from your health care provider concerning your child's cancer status. Preference is given to those residing in Greene,Christian, Taney, and Stone Counties. Maximum amount available is $1,000.

Patient Name:_____ D.O.B:_____ SS#:_____

Address: _____ City:_____ Zip:_____ - _____

Parent/Guardian Name: _____ Email:_____ County:_____
_____

Phone No.: _____ Children at home and ages: _____ Other Dependents: _____
_____ _____
_____ _____
Medical Diagnosis:_____ _____ _____
_____ _____ _____

Physician(s):_____ _____ _____

Amount Requested: _____

Please state the intended use for the funds requested: _____
_____

Other Agencies from which you are currently receiving funds: _____
_____

What kinds of services are being provided: _____
_____

Employer (if applicable)_____

Health Coverage: ____No ____Yes If yes, Circle type: Personal Policy, Through Employer, Medicare, Medicaid

CFO pays to invoice only. Cash is not provided.

Amount Requested: _____

FINANCIAL INFORMATION: (For office use only)

		Monthly Income		Monthly Expenses
Employment:	Parent(s):	$_____	Rent/Mortgage:	$_____
	Guardian:	$_____	Utilities:	$_____
	Other:	$_____	Food:	$_____
Retirement:	Social Security:	$_____	Insurance Health:	$_____
	VA Pension:	$_____	Insurance Home:	$_____
	Employee Pension:	$_____	Insurance Car:	$_____
Other Income:	Alimony:	$_____	Medical:	$_____
	Child Support:	$_____	Auto Payment:	$_____
	Investments:	$_____	Credit Card Debt:	$_____
	Public Assistance:	$_____	Other Expenses:	
	Workmen's Comp:	$_____	_____	
	Unemployment:	$_____	_____	
	Disability:	$_____	_____	
	Insurance:	$_____	_____	
	Savings:	$_____	_____	

Assets: (If more space needed, please attach separate sheet) **Value**

_____ _____
_____ _____
_____ _____
_____ _____

By signing this form you are agreeing that the Community Foundation of the Ozarks can receive information verifying your child's cancer status. I hereby certify that my son / daughter has been diagnosed with cancer and requires financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

_____ _____

Date **Parent / Guardian / Other**

PLEASE RETURN TO: Community Foundation of the Ozarks, Attn: Ellen Neville-Verdugo at P.O. Box 8960, Springfield, MO 65801

OR CALL: 417-864-6199 for help with questions **E-Mail:** eneville-verdugo@cfozarks.org