The Ashley G Charitable Foundation, Inc.

P.O. Box 14, Pawleys Island, SC 29585
Phone: (843) 458-8656
Email: david@ashleygfoundation.com
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APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION **(Please Print Clearly)**

First Name:_____Last Name:_____ Today's date:_____

Address: _____ City, State, Zip:_____

Phone Number: Home ( )_____ Work ( )_____

Cell: ( )_____ Email Address: _____

Date of Birth: _____ If patient is a minor (under 18), name of parent or guardian: _____

☐ Male ☐ Female Ethnicity: ☐ White ☐ African American ☐ Latino ☐ Asian ☐ Other _____

MEDICAL INFORMATION *****THIS SECTION MUST BE COMPLETED BY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY*****

Date of Diagnosis: _____ Primary Cancer: _____ State _____

☐ New Diagnosis ☐ Recurrence **Is patient in active treatment? ☐ Yes ☐ No**

If not in active treatment, indicate frequency of follow-up: ☐ Yearly ☐ Every Six Months ☐ Other _____

Please indicate type of treatment(s) received in past twelve months (check all that apply)

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative care ☐ Bone marrow/stem cell transplant

*****PLEASE COMPLETE ALL FIELDS ABOVE*****

HEALTH CARE PROFESSIONAL INFORMATION (please print):

MD Name: _____ Hospital/Clinic: _____

Address: _____ City, State, Zip: _____

Phone: ( ) _____ Fax: ( ) _____

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):

_____

Phone: ( ) _____ Email: _____

Your relationship to person applying for help: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ ACS Hospital Patient Navigator

Signature of MEDICAL PROFESSIONAL: _____ Date: _____

Incomplete Application Cannot Be Accepted

APPLICANT'S NAME: _____ **DOB:**_____

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? ☐ **Yes** ☐ **No**

If yes, please indicate type of insurance (check all that apply):

☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Medicare Plus Medigap ☐ Charity Care ☐ VA Program

Are prescription drugs covered? ☐ **Yes** ☐ **No**

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ☐ **Yes** ☐ **No**
Number of people in household: _____

FAMILY INCOME SOURCES (please check all that apply):

☐ Social Security (retirement) ☐ Salary ☐ Pension ☐ Unemployment
☐ Public Assistance ☐ Short-Term Disability ☐ SSD (Disability) ☐ SSI
☐ Family/Friends provide support ☐ Other – Specify: _____

TOTAL ANNUAL FAMILY INCOME*: $_____**
*****Application will not be processed if this information is not provided*****

FAMILY ASSETS (provide total amount in all accounts that apply):
Checking/Money Market: $_____ Savings/CD: $_____
IRA/403B/401K: $_____ Stocks & Bonds: $_____

TOTAL FAMILY ASSETS*: $_____**
*****Application will not be processed if this information is not provided*****

FINANCIAL ASSISTANCE NEEDS (Check All That Apply):

I need help with the following cancer-related expenses:

☐ Transportation ☐ Child Care ☐ Home Care ☐ Pain Medications ☐ Living Expenses

☐ Medical Expenses Not Covered by Insurance or Insurance Co-Payments

Please be aware that funds are limited and based on availability.
Patients must also meet The Ashley G. Charitable Foundation, Inc.'s eligibility requirements.

Signature:_____ **Date:** _____

Relationship to person applying for help: ☐ Self ☐ Spouse ☐ Family Member/Caregiver ☐ Health Care Professional

THANK YOU.

Mail this form to: The Ashley G. Charitable Foundation, Inc., P.O. Box 14, Pawleys Island, SC 29585
The Ashley G. Charitable Foundation, Inc. will review this information and contact the person requesting financial assistance.
All information is strictly confidential and is for the Ashley G. Charitable Foundation, Inc. use only.