Partners of Hope Application for Assistance

MRN:_____ Age:_____

Zip:_____ Gender:_____ Race:_____

Number in Household: _____ Assistance requested: _____

Round trip mileage (transportation assistance):_____

Insurance Status:

Medicare/Replacement	
Commercial Insurance	
Self- Pay	
Medicaid **	
Compassionate Care**	

Household Income *(**Not needed if Medicaid or Compassionate Care):*

Wages	
Unemployment	
Disability	
Social Security	
Retirement	
Other	
Total:	

	Yes	No	If yes, please describe the assistance you received
Are you enrolled with a local cancer service organization?			
Have you received other assistance from Mary Bird Perkins Cancer Center?			

I understand that completion of this application only means I will be reviewed for eligibility for assistance, and does not automatically mean I will receive the requested assistance. I further declare that my answers on this application are true and complete.

_____ _____

Initials Date

Staff use only:

Requesting employee: _____ Department: _____

Contact Phone Number: _____ Email: _____

Center Requested for (circle**):** MBP-OLOL MBP@STPH MBP@TGMC Hammond Gonzales

Amount Requested: _____Vendor Name_____

Why are these funds being requested and how will they be used? Have other resources been exhausted?

_____

_____

_____

_____

_____

Requesting Staff Signature/Date: _____