CELMA MASTRY OVARIAN CANCER FOUNDATION

Family, friends and community unite to fight ovarian cancer.

Application for Financial Assistance

Please email completed forms to **ccarlan@cmocf.org** or fax printed form to **727-490-1999**

Applicants must reside in the Tampa Bay area • PLEASE PRINT

Applicant Contact Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____ Country _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Email address _____

How do you prefer to be contacted? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Applicant Personal Information

Date of Birth _____ Place of Birth _____

Highest Level of Education ☐ High School Diploma / GED

College: ☐ Associates ☐ Bachelor's ☐ Master's ☐ Doctorate

Occupation _____ Employed? ☐ Yes ☐ No ☐ Self

Employer _____ Supervisor _____ Years Employed _____

Address of Employer _____

Employer Phone Number _____ Annual Income _____ Total of Additional Income Sources/Assistance/Support _____

Applicant Household Information

You currently live in: ☐ Apartment ☐ Home ☐ Condominium
☐ Public Housing ☐ Shelter ☐ With Friends/Relatives

$ Rent | $ Mortgage | $ Car Payment | $ Insurance Premium | $ Total Monthly Utility Expenses (Water/Power/Phone/Cable)

Do you own a car? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Widowed
☐ Divorced ☐ Separated

Name of: ☐ Spouse ☐ Guardian ☐ Caregiver

Address (if different than applicant)

Above Person's Employer | Supervisor | # of Years | Phone

Number of minors or dependents living with you full time | Ages | Number of Adults in Household

Do they contribute to household expenses? ☐ Yes ☐ No

Applicant Health Insurance Information

Insurance Provider

Address of Provider

Phone Number | Name of Insured

Type of Policy: ☐ Individual ☐ Family ☐ Corporate
☐ Government ☐ Other

Policy Number | Group Number

Do you have disability insurance? ☐ Yes ☐ No

Do you have life insurance? ☐ Yes ☐ No

Monthly Premium Amount | Other Insurance

Applicant Medical Information

Date of Diagnosis

Primary Cancer

Stage of Cancer

New Diagnosis

Reoccurence

Are you in active treatment? ☐ Yes ☐ No

If yes, please explain

If no, is post follow-up treatment needed? ☐ Yes ☐ No

If yes, what type of follow-up? ☐ Yearly ☐ Six Months ☐ Other _____

Name of Applicant's Physician

Name of Hospital or Clinic

Address

City

State

Zip

Country

Email

Phone

Fax

Applicant Authorization, Release of Information and Request for Funds

I _____ hereby authorize representatives of the Celma Mastry Ovarian Cancer Foundation to contact those physicians and medical professionals and institutions involved with my health care and authorize them to release any and all information regarding my condition and health status. I also attest that the information submitted on this form is true and correct to the best of my knowledge and formally request the amount of $_____ from the Foundation for my _____ expenses. All information submitted is considered confidential and will only be used by the Foundation and its members to determine eligibility of applicant.

Signature

Date

How did you hear about our Foundation and/or who referred you to us?