Cancer Care Foundation of Tidewater

Direct Patient Assistance Application

APPLICATION MUST BE SUMBITTED BY A MEDICAL PROFESSIONAL

STEP 1 - Completed by LCSW/Patient Navigator/Medical Professional

Name of LCSW/Medical Professional:_____

Telephone: _____Email: _____

Date: _____ Signature of LCSW/Medical Professional:_____

Specific assistance requested:

☐ ***household expense bill – please attach (we cannot process urgent shut-off notices or rent)***

☐ ***other (please specify):*** _____

Patient Name: _____ Date of Birth _____

Patient Address:_____

Street Apt # City Zip

Patient Preferred Phone: _____ Please circle: Male Female

Name of Oncologist/Specialist:_____

Patient Diagnosis:_____

What makes this humanitarian grant request a priority?_____

_____

_____

_____

STEP 2 – To be completed by the Patient

PATIENT PERMISSION (PATIENT MUST SIGN FOR APPLICATION TO BE CONSIDERED COMPLETE)

Cancer Care Foundation of Tidewater (CCFOT) is a nonprofit organization chartered by the Commonwealth of Virginia. We will act on your behalf for limited financial aid, information and assistance. I, _____(print name), according to the Privacy Acts legislated for the confidentiality and privacy of my health information, do hearby permit release of my information for this foundation and cognate agencies that may be contacted in discussing my non-medical needs. Please sign/date to signify permission to release information to CCFOT.

Patient Signature:_____Date:_____

Submit applications BY FAX ONLY to 757-461-1778. Please allow up to 2 weeks for email notification of disposition of complete grant applications. We rely on LCSW to communicate with patients.

Please do not instruct patients to call our office. **Thank you.**