Patient Assistance Grant Application

Stan Wong Foundation
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www.stanwongfoundation.org
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GRANT GUIDELINES:

- To qualify, a patient must be a "local": a resident of Long Island in New York.
- Grants are awarded based on need and preference will be given to applications received first.
- Each grant application may be awarded a maximum of $1,000 for qualifying expenses.
- If additional assistance is needed, and there are available funds, a patient may apply for additional grant funds by submitting an additional grant application.

Stan Wong Foundation
Patient Assistance Application

Date: _____

I. Patient Name:_____

Patient Address: _____

Town:_____ State: _____ Zip Code: _____

Phone #: _____ e-mail: _____

Diagnosis: _____ Date of Initial Diagnosis: _____

II. Name of Primary Care Physician: _____ Phone #: _____.

Name of Primary Oncologist: _____ Phone #:_____

III. Caregiver's Name (if applicable): _____

Address: _____ Town:_____ State: _____ Zip Code:_____

Is the caregiver filling out this application for the patient? Yes No

Is the caregiver the patient's legal health care proxy? Yes No

If No, please provide the name and contact information for the patient's legal health care proxy:

IV. Current Health Status (**please provide supporting documentation from your physician)**:_____

_____

_____

_____

V. Describe the areas where you need assistance. Attach separate sheet if more room is needed.

All expenses must be resulting from your cancer diagnosis.

a. Medical Expenses. This can include doctor & hospital bills, nursing & care services, as well as medical supplies or medications. (include copies of bills, quotes or receipts):

b. Living expenses (These must be expenses that you cannot pay due to your inability to work as a result of your cancer, please include copies of those bills):

c. Other (Including services or assistance needed, monetary or non-monetary, EX: transportation, advocacy, educational, encouragement & support services):

IMPORTANT NOTE: Financial assistance will be provided directly to the vendor for services rendered or products needed. In order to avoid delay, it is important that you include with this application copies of receipts, bills, quotes, etc. that provide documentation for the needs requested. These documents should include the name and address of the payee.

Applicant Declaration

I certify that all information I have provided in this application, including any attachments, is accurate and complete to the best of my knowledge. I understand that approval of my application may be contingent upon review and verification of the information provided. I hereby authorize the Stan Wong Foundation (SWF), and its agents to investigate the truthfulness and accuracy of all information I have provided. I authorize SWF, and its agents to discuss any medical information resulting from my cancer diagnosis or effecting the treatment of such diagnosis with all persons involved in the my medical treatment. I give consent for all my caregivers and physicians to provide information concerning me and/or my application, and I release each such person from liability for providing information to SWF, and its agents. I understand that any false or misleading statement, misrepresentation, or concealment or material omission of the information I have provided or failed to provide on my application and attachments may be grounds for rejection of my application.

I also understand that any disputes or conflicts arising from the processing, review or rejection of the application or subsequent review or rejection of submitted supporting materials will be resolved by the SWF, and will receive a final and indisputable review for resolution by the SWF Board of Directors. I agree, indicated by my signature, that all legal disputes arising from this application, its review or rejection, will de heard in a court in the home county of record of the SWF.

_____ _____

Patient's Signature Date

If patient is unable to sign this application, the patient's health care proxy must sign, and provide documentation verifying they are legally assigned as the patient's health care proxy.

_____ _____

Signature of Patient's Legal Health Care Proxy Date