Avila's Cancer Fund

info@avilascancerfund.org

Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Annual Income _____ Request Amount.: _____ Cell Phone: _____

Intended use of grant: _____

Do you have health insurance? YES ☐ NO ☐ Do you travel for treatment? YES ☐ NO ☐

Do you have a 48-hour notice? YES ☐ NO ☐ If yes, where? _____

Have you been served an eviction notice? YES ☐ NO ☐

If yes, explain: _____

Our Guidelines

1.Must be in current treatment verified by a social worker & physician office with a medical information form.
2. Applications must be signed by the patient. All forms may be emailed if you wish to come in please contact Avila's Cancer Fund for an appointment.
3. You must have valid ID, Driver's License, or verification of identity.
4. All payments will be paid directly to the vendor such as PG&E, Utilities, Landlord or Mortgage Company, Co-Pays are made out to the facility or physician's office. A copy of the bill must be submitted prior to payment. For lodging request a minimum of 40-mile distance from the treatment facility this is a case-by-case basis.
5. Avila's' Cancer Fund offers financial assistance, and food cards while funds are available.
6. You can apply for financial assistance every six months from your first application.
7. Please allow 5-10 days from receiving the application to be notified.

Patient Verification

Facility _____ Phone: _____

Address: _____ Direct Number: _____

Name& Title: _____ email: _____ Date: _____

Patient Name: _____

Patient DOB: _____ : _____ Physician Name: _____

Does patient travel over 40 miles for treatments and appointments? YES ☐ NO ☐

Signature

I certify that my answers are true and complete to the best of my knowledge.

By signing this application, you are attesting to the accuracy of the information. Please make sure you have completed the application patient signature is required and a copy of identifications.

Social Worker, Physician Office Signature: _____ Date: _____

Patient Signature: _____ Date: _____