



Quick Application for Financial Assistance

Please provide us with the information requested below, understanding that the submission does not confirm your eligibility for any financial assistance and additional information may be needed in the future.

Name: _____

Street Address: _____

City: _____ County: _____ Zip Code: _____

Mailing Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ Email: _____

Social Security Number (Required): _____ - _____ - _____

Diagnosis: _____

Name of Employer: _____

Phone: _____

Do you have...?

Primary health insurance? _____ Company: _____

Secondary health insurance? _____ Company: _____

Medicare _____ Medi Cal? _____ Disability? _____ Other: _____

Have you applied for any of the above? _____

Tell us about your household:

	Name	Age
Adult 1	_____	_____
Adult 2	_____	_____
Child 1	_____	_____
Child 2	_____	_____
Child 3	_____	_____

Name of Physician: _____ Phone: _____

Name of Oncologist: _____ Phone: _____

Name of Oncology/ Social Worker: _____ Phone: _____

Hospital Affiliation: _____ Phone: _____

Are you currently in treatment for your cancer? _____ What kind of treatment are you receiving? _____ How often? _____

When will it end? _____

What type of help are you seeking?

____ Assistance with seeking additional medical treatment options such as:

____ Special needs for my family during diagnosis/treatment such as: _____

____ Help with the following expenses during diagnosis/treatment: _____

Please provide us with any information you believe is important for us to know regarding your request for financial assistance: _____

How were you referred to The Pendleton Foundation? _____

Are you related to or do you know anyone associated with The Pendleton Foundation? _____

Date Application Completed: _____



Authorization for Release of Information

To ensure the continuity of my medical care I hereby authorize the Pendleton Foundation and its representatives to discuss my Application for Financial Assistance, (including but not limited to my financial information, diagnosis and treatment) and related medical care with my physicians, medical representatives and financial advisors, as needed. I also authorize the release, as needed, of any medical records and information by my medical providers to the Pendleton Foundation.

Patient/Legal Guardian

Witness

Print Name

Print Name

Date

Date

Pendleton Foundation Representative

Date Reviewed

Waiver and Release

In consideration of my acceptance of financial aid or benefits from The Pendleton Foundation, I hereby, for myself, my heirs, my executors and administrators, waive any and all claims I may have against The Pendleton Foundation, Inc., its employees, agents, representatives, assigns, and anyone else working with them, as well as all participating groups and any other individuals associated with The Pendleton Foundation, their representatives, successors and assigns, and hereby agree to hold harmless The Pendleton Foundation, Inc. as well as all of these individuals and groups for any and all injuries and/or damages that may be sustained by me in any manner arising out of or in connection with The Pendleton Foundation.

In addition to the foregoing, and in further consideration of my acceptance of financial aid or benefits from The Pendleton Foundation, I hereby grant my permission to The Pendleton Foundation, Inc. to use my image and any photos, motion pictures, recordings, or any other form of record for this event for any legitimate purpose. Furthermore, I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

In filling out this form I acknowledge I have read and fully understand the terms of this Waiver and Release and expressly agree to all such terms without reservation.

Dated: _____

Signed: _____

Print Name: _____

Please return to:
The Pendleton Foundation
68-929 Perez Road, Suite E
Cathedral City, CA 92234
Phone: 760-202-6157
Fax: 760-699-2946

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