# Jolly John's "Keep You Truckin" Fund, Inc

**Attn: Donna Wallace, PO Box 308, Columbia, CT 06237**

**Email: dwallace@columbiaford.com**Phone: 860-228-2886 ext 151**Fax: 860-228-0472**

## APPLICATION FOR ASSISTANCE FOR CT RESIDENTS RESIDING IN NEW LONDON, TOLLAND & WINDHAM COUNTIES

**PATIENT INFORMATION (PLEASE PRINT CLEARLY)**

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Address (No PO Box): | City, State, Zip: | |
| Phone number: Home ( ) | Work ( ) | Cell ( ) |
| Email Address: | Date of Birth: | |
| If patient is a minor (under 18), name of parent or guardian: | | |
| ☐Male ☐Female ------ | Ethnicity: ☐White ☐African ☐American ☐Latino ☐Asian ☐Other | |

*****MEDICAL INFORMATION *** THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY**

| | | |
|---|---|---|
| Date of Diagnosis: | Primary Cancer: | Current Stage: |
| New Diagnosis: | Recurrence : | Is patient in active treatment? ☐Yes ☐No |

**If not in active treatment, indicate frequency of follow-up: ☐Yearly ☐Every 6 months ☐Other**

**Please indicate type of treatment(s) received in past twelve months (check all that apply)**

☐Chemotherapy ☐Radiation ☐Surgery ☐Hormonal ☐Palliative Care ☐Bone marrow/stem cell transplant

***** PLEASE COMPLETE ALL FIELDS ABOVE AND PROVIDE A BRIEF SUMMARY ON BEHALF OF PATIENT*****

**HEALTH CARE PROFESSIONAL INFORMATION (PLEASE PRINT CLEARLY)**

| | |
|---|---|
| Physician Name: | Hospital/Clinic: |
| Address: | City, State, Zip: |
| Phone: ( ) | Fax: ( ) |

**Name and title of person completing this section, if different than above (please print)**:

| | |
|---|---|
| Phone: ( ) | Email Address: |
| Your relationship to person applying for help: ☐Doctor Nurse ☐Social Worker ☐ | |

**Signature of MEDICAL Professional:**

**HEALTH INSURANCE INFORMATION**

Does the patient have health insurance? ☐Yes ☐No

If yes, please indicate type of insurance (check all that apply):

☐Private insurance ☐Medicaid ☐Medicare ☐Medicare plus Medigap ☐Charity care ☐VA program Husky

Are prescription drugs covered? Yes ☐No

Is Dental covered? Yes ☐No

# Jolly John's "Keep You Truckin" Fund, Inc

**Attn: Donna Wallace, PO Box 308, Columbia, CT 06237**

**Email: dwallace@columbiaford.com**Phone: 860-228-2886 ext 151**Fax: 860-228-0472**

## APPLICATION FOR ASSISTANCE FOR CT RESIDENTS RESIDING IN NEW LONDON, TOLLAND & WINDHAM COUNTIES

**HOUSEHOLD FINANCIAL INFORMATION**

Is patient currently employed? ☐Yes ☐No Number of people in household:

**Family Income Sources (please check all that apply):**

☐Social Security (retirement) ☐Salary ☐Pension ☐Unemployment ☐Public Assistance ☐Short-term Disability

☐SSD (Disability) ☐SSI ☐Family/friends provide support ☐Other - specify

## Acceptable proof of income:**

**First two pages of signed copy of income tax return (you may blacken social security #)**

**OR**

**If you do not file a tax return: Copies of most recent pay check, unemployment check, SSI, SSD, public assistance benefit notification**

| **Total Annual Family Income** | **$** |
|---|---|

*****Application will not be processed if this information is not provided*****

**FINANCIAL ASSISTANCE NEEDS (PLEASE CIRLCE ALL THAT APPLY)**

**I need help with the following cancer-related Living/Medical expenses.

Rent ☐Mortgage ☐Utility Bill ☐Insurance Deductible Insurance Payment Medical Bill Dental Bill ☐ Mastectomy Bras Other

**** Copies of most recent lease, billiing statements and a complete W9 for each entity you are requesting payment to**

Relationship to person applying for help:

☐Self ☐Spouse ☐Family member/caregiver ☐Health care professional

**I hereby acknowledge and represent the information provided is true, correct and complete to the best of my knowledge. I further understand that false information constitutes grounds for refusal of Jolly John's "Keep You Truckin" Fund. By way of my signature I attest that any financial assistance provided will be used for the expense indicated above.**

**Patient Signature: _____ Date:_____**

*******All expenses will be paid by check directly to the service provider from fund.*******

**Please be aware that funds are limited and based on availability as well as on meeting eligibility requirements.**

**Date Received:_____**

**Approved or Denied Date:_____**

# Jolly John's "Keep You Truckin" Fund, Inc

**Attn: Donna Wallace, PO Box 308, Columbia, CT 06237**

**Email: dwallace@columbiaford.com**Phone: 860-228-2886 ext 151**Fax: 860-228-0472**

## APPLICATION FOR ASSISTANCE FOR CT RESIDENTS RESIDING IN NEW LONDON, TOLLAND & WINDHAM COUNTIES

**Amount Approved: _____Paid Date:_____Ck#_____**