ROTARY CLUB

of CLINTON, CONNECTICUT

P.O. BOX 558 CLINTON, CT.

Clinton Rotary Cancer Relief Fund Application for Assistance

Date: _____

Patient Name: _____DOB: _____

Patient Address: _____

Town/City_____ State_____ Zip_____

Home Phone: _____ Cell Phone _____

Referred by: _____ Phone:_____

Patient Employment Information

Employer: _____ Yrs. Employed: _____

Address: _____ Town/City _____

State: _____ Zip: _____ Phone:_____ Contact:_____

Number of people living in household: _____
Ages of all in household: _____

Are all people living in household employed? Yes / No
If so, Who: _____
Where: _____ How long: _____

Do they contribute to the household? Yes / No
Is anyone living in the house on Disability? Yes / No
If so, what is the total of their Disability? $_____

Reason for Disability_____

Name of Person(s) other than patient residing in home _____
DOB: _____
Monthly Income: $_____

Name: #2 _____
DOB: _____
Monthly Income: $_____

Are there any Veterans Living in Household? Yes / No
Who: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Date of Diagnosis:_____ Primary Cancer Site(s):_____
Metastatic Site (s):_____ Location(s): _____
Surgery Date:_____ Palliative Care: _____
Radiation Start Date: _____ Completion Date:_____
Chemo Start Date:_____ Completion Date: _____

CURRENT CLINICAL STATUS

Is Cancer Major Cause of Disability? Yes / No

Pain Status (Circle One): Mild Moderate Extreme

Co-Morbid Medical Problems? Yes / No

If yes, please list _____

Prognosis/Disease Status (Circle One):

Stable Responding to Treatment Terminal

Psychological Status: _____

Expected Disability Duration: _____

Free of Disease: Yes / No

Progressing: Yes / No

ATTENDING PHYSICIANS STATEMENT
(To be completed and signed by the attending physician)

Date _____

Patients Name: _____

Address: _____

City / Town: _____

State: _____ Zip Code: _____

Name of Doctor (please print): _____

ID #: _____

Name of Practice: _____

Address: _____

City / Town: _____

State: _____ Zip Code: _____

Phone: _____

Date of when you first treated patient: _____

Is patient still under your care? (circle one): Yes / No

Approx. Length of Disability: _____

Signed (Physician) _____ Date: _____

Patient Name: _____

Address: _____Town_____St_____ Zip_____

Phone:_____ Soc. Worker:_____ SW/ID#_____

Personal Financial Information
(To be completed by Patient)

BASIC MONTHLY EXPENSES ***

Rent/Mortgage $_____

Electric Bill $_____

Heat (oil/gas) $ _____

Propane Gas $_____

Car Payment $_____

Car Insurance $_____

Phone Bill $_____

Groceries $_____

Property/Car Taxes $ _____

MONTHLY INCOME (All Sources)

(Include all household members)

Net Salary $_____

SS/SSDI $_____

Pensions $_____

Other Income $_____

Total Monthly Income $_____

Savings/IRA $_____

Money Market/stocks $_____

Total Assets $ _____

Please do not include Medical insurance or Medical co-pays in your monthly expenses as we do not cover any Medical expenses at all, only living expenses.

TOTAL MONTHLY EXPENSES $_____

Signature (Patient) _____ Date _____

Please include a <u>current</u> copy of the following statements in with your submitted application:

_____ CL&P _____ Phone _____ Mortgage / Rent _____Property Tax
_____ Oil/Gas _____ Cable _____ Other

Medical Release Form

I, _____ (patient's name), hereby authorize my attending physician, _____ (Physician's name), to release my medical information for review to the Clinton Rotary Cancer Relief Fund for the sole purpose of financial assistance consideration. The information released shall be held in strict confidence and not released beyond the CRCRF.

Signature (Patient) _____ Date _____

Mail Applications to:

CRCRF
P.O. Box 558
Clinton, CT. 06413