Ryan Lee Holland Cancer Foundation, Inc.

www.ryanleehollandfoundation.org

PATIENT APPLICATION FOR ASSISTANCE

The Ryan Lee Holland Cancer Foundation, Inc., hereafter The Foundation, provides financial assistance to cancer patients in active treatment. **Please know that assistance is on a first come first serve basis and is based on availability of funds.** All applications must be filled out and signed. Incomplete applications will not be considered. Please Print.

Patient Information

Name: _____ Today's Date: _____

Address: _____ City, _____ State, _____ Zip,_____

Home # _____ Work # _____ Cell # _____

Email Address: _____

Date of Birth _____ If patient is a minor (under 18), name of parent or guardian:_____

*Gender: ☐ Male ☐ Female * Ethnicity: ☐ White ☐ African American ☐ Latino ☐ Asian ☐ Other
*For Demographics Only (Not required and has no bearing on service eligibility)

What type of assistance are you requesting? Select One

☐ Medical Co-Pay ☐ Office Visit Co-Pay ☐ Prescription Assistance ☐ Travel/Parking Assistance

How did you hear about us? ☐ Website ☐ Doctor ☐Social Worker ☐ Friend/Family ☐ Other _____

All information I have provided is true and correct. I authorize The Foundation to contact my health care provider(s) listed below, and I authorize my health care provider(s) to release information to The Foundation related to this application only. I understand that providing false information will result in denial of assistance. ONLY COMPLETED APPLICATIONS WILL BE CONSIDERED.

Signature of Applicant: _____ Date: _____

THIS SECTION MUST BE COMPLETED BY DOCTOR, NURSE, SOCIAL WORKER OR HOSPITAL

Date of diagnosis: _____ Primary Cancer _____ Stage _____

Is patient in active treatment? ☐Yes ☐ No

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

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Bone Marrow / Stem Cell Transplant ☐ Palliative Care

Healthcare Provider Name:_____ Hospital/Clinic:_____

Address: _____ City, State, Zip _____

Phone: ( )_____ Fax: ( )_____ Email:_____

Signature of Medical Professional: _____ Date:_____

THIS SECTION TO BE COMPLETED BY THE FOUNDATION ONLY

Date Received: _____ Date of Approval: _____ Assistance Amount $_____
Approved By: _____ Check # _____ Check Date _____

Fax this form to: (678) 288-7949 or Mail to: Ryan Lee Holland Cancer Foundation, Inc. 11877 Douglas Rd., Ste. 102-262, Alpharetta, GA 30005
The Foundation will review this information and may contact the person requesting financial assistance.
All information is strictly confidential and is for the Foundation's use only.