A Foundation Inspired by Strength

Please mail this completed form to: Suz Crew, PO Box 466, Montrose, NY 10548

Please complete and sign application before submitting to the physician for signature. Once all requested information is received, please allow 5 - 7 business days to process the application.

If you have any questions regarding this application, please email us at info@suzcrew.com.

Date: .....

Last name: ..... First name: .....

Date of birth: ..... Social Security #: .....

Address: .....

City: ..... State: ..... Zip: .....

Home phone: ..... Cell phone: .....

E-mail: .....

Is the patient under 18 years old? ☐ Yes ☐ No (If yes, please provide the name of his/her parent or guardian):

Last name: ..... First name: .....

How did you hear about *Suz Crew*? .....

.....

Describe your situation as best you can: .....

.....

.....

.....

Financial assistance is requested for:

☐ Transportation ☐ Child care during treatment ☐ Food ☐ Mastectomy products, hair pieces, etc.

☐ Lodging ☐ Rent/mortgage ☐ Other

Please explain: .....

.....

.....

.....

Are you currently employed? ☐ Yes ☐ No

Employer Name .....

Address .....

Contact ..... Phone .....

Do you have health insurance (including Medicare/Medicaid)? ☐ Yes ☐ No

Insurance Company Name .....

Have you applied for assistance from other sources? ☐ Yes ☐ No (If yes, please list names & amounts received)

Organization name: ..... Amount received: $ .....

Total Monthly Income: $ .....

Monthly Expenses: Rent/Mortgage $ .....
Child care $ .....
Health Insurance $ .....
Transportation $ .....
Food $ .....
Utilities (electric, water, phone) $ .....
Medical Bills/Other Debt $ .....
Total $ .....

Family Assets: Checking $ .....
Savings/CD$ .....
Other $ .....
.....
.....
Total $ .....

Income Source (Please check all that apply)

☐ Retirement/Pension ☐ Public Assistance ☐ Short Term Disability ☐ Unemployment
☐ SSD (Disability) ☐ Interest and Dividends ☐ Salary

**Please attach copies of the following:**
❶ Proof of residency for more than 1 year (i.e. lease agreement, deed, or tax return)
❷ Photo ID
❸ Copy of bill for which financial assistance is requested (if applicable)

**Patient/Parent signature**

I certify with my signature that to the best of my knowledge, the financial information I have provided is complete and accurate. I understand that the information I have given is subject to verification by Suz Crew. I also understand that I am responsible to inform Suz Crew of any change in my financial status. I further understand, that Suz Crew funds are limited and grants are made based on availability. The final determination of qualification for financial assistance is by the governance of it's Board of Directors.

Signature ..... Date signed .....

**To be completed by patient's doctor**

Date of diagnosis .....

Is the patient in active cancer treatment, within 6 months of a diagnosis of cancer, within 6 months of completing treatment, in need of cancer screening and in need of financial assistance? ☐ Yes ☐ No

Physician name: .....

Hospital/Clinic: .....

Address: .....

City: ..... State: ..... Zip: ..... Phone: .....

Office contact name: ..... Phone: .....

Physician signature: ..... Date: .....

**SUZ CREW OFFICE USE ONLY**

Financial assistance committee review: ☐ Approved ☐ Not Approved Application # .....

Amount given $ ..... Date given ..... Payee .....