Please send your completed application to:
“The Distribution Committee”
Stephen A. Comunale, Jr. Family Cancer Foundation
P.O. Box 13805 Akron, Ohio 44334
Fax: (330) 835-5978
info@stephencomunale.org

WHO IS ELIGIBLE FOR ASSISTANCE?
- Any family who has a member receiving active treatment for cancer (i.e., treatment within the past year)
- The applicant must reside OR be treated in Summit County
- Applicant must show need of assistance by providing verification and documentation

WHAT IS COVERED?
- Rent or mortgage payments
- Utility bills (excluding nonessential utilities such as cable TV and internet connections)
- Other day-to-day financial needs may be considered
- Please note, payment for all of the above is made directly to the provider, not the patient or family

HOW CAN YOU APPLY FOR ASSISTANCE?
- Complete the attached application form in its entirety. All information will be verified. Incomplete applications will be returned.
- The application must be accompanied by copies of actual recent bills
- Applications must be submitted to Stephen A. Comunale, Jr. Family Cancer Foundation for processing.

An independent committee of the Foundation will review requests.
Application for Financial Assistance

Referred to the Foundation by: ____________________________ (required)

Patient Information (Please Print, All Fields Required)

Last Name, First Name: ____________________________, ____________________________ Date: ______________

Address: __________________________________________ City/State/Zip: ____________________________

Phone: (___) ____________________________ Male: ______ Female: ______

Age: ______ Date of Birth: ____________________________

Number in Household: ______ Number of Dependents (under 18): ______

If patient is a minor, name of parent/guardian: ________________________________________________

Currently Employed? Yes: ______ No: ______ Spouse Currently Employed? Yes: ______ No: ______

Total Monthly Household Income: (including spouse, additional family, social security, disability, child support, etc.): $____________

If you have received previous support from our Foundation, please list month and year: ______________

If you have received assistance from other organizations, please list date and amount: ____________________________

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Physician/Treatment/Insurance Information (All Fields Required)

Last appointment: ________________ Next appointment: ________________

Oncologist’s Name: ____________________________________________

Hospital Name: ____________________________________________ Phone: (___) ____________________________

Social Worker: ____________________________________________ Phone: (___) ____________________________

Primary Cancer: ____________________________ Stage of Cancer: ______

Are you in active treatment (treatment within the last year)? Yes: ______ No: ______

If yes, please check all that apply? Chemotherapy: ______ Radiation: ______ Surgery: ______

Do you have health insurance? Yes: ______ No: ______

If yes, name of insurance company: ____________________________________________________________
Application Privacy Statement

The Stephen A. Comunale, Jr. Family Cancer Foundation protects the privacy of our applicants/patients and assures the confidentiality of information regarding your medical history. Your medical history will only be shared with the Distribution Committee of the Stephen A. Comunale, Jr. Family Cancer Foundation, its agents and any references supplied by you in the application including, but not limited to the Stephen A. Comunale, Jr. Family Cancer Foundation staff, physicians and other assisting agencies. Due to the fact that the Stephen A. Comunale, Jr. Family Cancer Foundation is a cancer related organization, your creditors may become aware of the fact that you are a cancer survivor.

Signature of Patient or legally authorized representative

________________________________________________________

Print name of patient or legally authorized representative

________________________________________________________

Description of legally authorized representative’s authority

Verification Permission

I give my permission to the Stephen A. Comunale, Jr. Family Cancer Foundation for verification of all information provided in this application including any bills and personal medical/hospital statement.

Signature of Patient or legally authorized representative

________________________________________________________

Print name of patient or legally authorized representative

________________________________________________________

Description of legally authorized representative’s authority
Share Your Story

In your own words, please tell us your story including diagnosis and treatment. This is your opportunity to tell the human side of your cancer journey and the challenges it has caused you and your family.

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