



**COMUNALE  
CANCER FOUNDATION**

**Send completed application to:**  
"The Distribution Committee"  
Comunale Cancer Foundation  
P.O. Box 13805 Akron, Ohio 44334  
Phone: (234) 706-0252 Fax: (330) 835-5978  
info@stephencomunale.org

### **MISSION STATEMENT**

The Comunale Cancer Foundation is a nonprofit charitable organization that endows an outreach program to provide comfort by easing the ancillary financial burdens that confront cancer patients and their families. Our advocacy efforts work through partnering with organizations and resource providers to enhance the quality of life and empower the individuals. The Foundation also funds other cancer nonprofits who provide services and programs to those touched by cancer.

### **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, Stark, Portage, or Medina 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.
- Please complete all sections truthfully. If information is found to be misleading, false, or inaccurate it will result in a disqualification of the application.
- The application must be accompanied by copies of actual recent bills
- Applications must be submitted directly to the Comunale Family Foundation for processing.
- *Incomplete applications will be returned.*

**An independent committee of the Foundation reviews all applications.**

For Office Use Only

### 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: \_\_\_\_\_

Are You Currently Employed? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**TOTAL** Monthly Household Income \$ \_\_\_\_\_

*(Total should include income of any household members age 15 or older including wages, tips, bonuses, retirement income, welfare payments, Social Security benefits, 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: \_\_\_\_\_

#### Physician/Treatment/Insurance Information (Please Print, 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: \_\_\_\_\_

**2025 Application for Financial Assistance**

**Financial Assistance and Documentation**

(Please check item(s) you are applying for assistance with below.)

- \_\_\_\_\_ Utilities\*
- \_\_\_\_\_ Mortgage\*
- \_\_\_\_\_ Rent\*
- \_\_\_\_\_ Gasoline Assistance
- \_\_\_\_\_ Food Assistance
- \_\_\_\_\_ Other\*

\*Application must be accompanied by copies of the actual bill(s) including account number and billing mailing address to be considered. Mortgage requests must include current payment information with account number and payment stub. Rent requests must include copy of lease. All incomplete applications or applications with missing documentation will be returned. Payment for all the above is made directly to the provider, not the patient or family.

**Application Privacy Statement**

The Comunale 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 Comunale Cancer Foundation, its agents and any references supplied by you in the application including, but not limited to the Comunale Cancer Foundation staff, physicians and other assisting agencies. Due to the fact that the Comunale 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient or legally authorized representative

\_\_\_\_\_  
Description of legally authorized representative's authority

**Verification Permission**

I give my permission to the Comunale 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
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.

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---