2025 Application for Financial Assistance

For Office Use Only

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.*

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An independent committee of the Foundation reviews all applications.

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: _____

Is your Spouse or Significant Other Currently Employed? Yes: _____ No: _____

TOTAL Monthly Household Income $_____
(Total should include income of any household members age15 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: _____

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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.