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APPLICATION FOR FINANCIAL ASSISTANCE

Date _____

Section 1: Patient Information

(Please print)

Last Name _____ First Name _____

Address _____ City/State/Zip _____

Phone Home () _____ Work () _____ Cell () _____

() Male () Female Age ____

If patient is a minor, name of parent or guardian _____

Section 2: Financial Information

Family Expenses and Assets Please provide copies of appropriate documentation

Monthly Family Expenses	Amount	Family Assets	Amount
Rent/Mortgage	\$	Checking	\$
Utilities/Phone	\$	Savings/CD	\$
Child Care	\$	Money Market	\$
Transportation	\$	Stocks	\$
Health Insurance	\$	Bonds	\$
Medical Bills	\$	Family Assets Total	\$
Food	\$		
Other (specify)	\$		
Monthly Expenses Total	\$		

- TOTAL Monthly Family Income _____
- Number in household _____
- Currently Employed () YES () NO If answer is YES, please answer the following:
- Employer _____ Length of employment ____ Position _____

Income Sources Please check all that apply and provide copies of appropriate documentation

<input type="checkbox"/> Social Security (retirement)	<input type="checkbox"/> Alimony	<input type="checkbox"/> Salary
<input type="checkbox"/> Pension	<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> In-Kind (room and board)	<input type="checkbox"/> Child Support	<input type="checkbox"/> Family/Friends provide support
<input type="checkbox"/> SSD (Disability)	<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSI <input type="checkbox"/> Sick Leave Pay
<input type="checkbox"/> Other: Specify _____		

- Where else have you applied for financial assistance? _____
- Are you now or will you be receiving assistance from another organization(s)? () YES () NO
- If YES, provide details and amounts _____

Section 3: Health Insurance Information

- Do you have health insurance () YES () NO
- If YES, please indicate type of insurance. Check all that apply.

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Public Health Insurance	<input type="checkbox"/> Medicare only
<input type="checkbox"/> Medicaid pending	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Medicare plus Medicaid
<input type="checkbox"/> Emergency Medicaid	<input type="checkbox"/> VA Program	<input type="checkbox"/> Medicare plus other supplemental coverage
	<input type="checkbox"/> Charity Care	

- Are prescription drugs covered? () YES () NO
- If YES, are they included in Section 2, under Family Expenses, Medical Bills? () YES () NO

Section 4: Assistance Needed

- Please list the exact needs for which you are requesting assistance and include cost. Examples are: transportation, living expenses, home care, household necessities.

Item	Cost	Additional comments

- If there are needs not covered above, please explain and provide costs.

Section 5: Signature of Person Completing This Application

I certify that to the best of my knowledge the information in Sections 1, 2, 3, and 4 above is accurate. I give permission for applicant's medical information requested in Section 7 of this form to be released to Team Continuum pursuant to this request for financial assistance.

Signature _____ Print Name _____

Relationship to person applying for assistance:

Self Spouse Parent Guardian Friend Caregiver Other, specify _____

Section 6: Social Worker Contact Information

If the applicant has a social worker, the following information is requested.

Name (Please print) _____ Title _____

Organization _____

Address _____ City/State/Zip _____

Phone () _____ Fax () _____ Email _____

Comments. Attach additional sheet, if needed.

Section 7: Medical Information

To be completed by your Doctor, Nurse, or Social Worker ONLY

Date of Diagnosis _____ Primary Cancer Diagnosis _____

- Stage of Cancer _____ () New Diagnosis () Recurrence
- In active treatment? () YES () NO

If the answer to whether the patient is in active treatment is YES, please indicate type of treatment.

Check all that apply

<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation	<input type="checkbox"/> Clinical trial	<input type="checkbox"/> Hormonal	<input type="checkbox"/> Surgery	<input type="checkbox"/> Palliative care
<input type="checkbox"/> Bone Marrow/Stem Cell Transplant			<input type="checkbox"/> Complementary/Alternative		

If the answer to whether the patient is in active treatment is NO, is post treatment follow-up needed?

() YES () NO

If the answer to whether post treatment follow-up is needed is YES, please indicate type of follow-up:

() Yearly () Every six months () Other _____

MD Name (Please print) _____

Hospital/Clinic _____

Address _____

City/State/Zip _____ Phone () _____ Fax () _____

Signature of person completing this section _____

Name/Title (Print) _____

Phone (if different than above) () _____ E-mail _____

**PLEASE FAX COMPLETED FORM TO: 212.951.7201
OR MAIL TO: TEAM CONTINUUM INC., 401 FIFTH AVENUE - FOURTH FLOOR, NEW YORK, NY
10016**

Funds are limited and based on availability. All information and documentation is confidential and for Team Continuum's use solely in consideration of this application.

The applicant will be contacted if additional information is needed.