APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for your interest in Joy of Dawn assistance for fighters!

Please fill out the attached application then mail to:

Joy of Dawn

226 Keller Ln. #7156

Maryville, TN 37801

Once Joy of Dawn receives the application, it may take up to 5 business days for review by the Joy of Dawn financial assistance committee.

APPLICATION FOR FINANCIAL ASSISTANCE

Name: ____Date of Birth: _____/______/______

Street Address: ________________________________Ethnicity (Optional) ______________

City: _____________State: ____________ Zip: _______County:________________________

Educational Level: ☐ High School ☐ College ☐ Trade School

Marital Status: ☐ Single ☐ Living together ☐ Married ☐ Divorced ☐ Widowed

Please list all members of household:

Name	Relationship	Age	Annual Income

Have you applied for Social Security Disability? Yes/No
Are you receiving Social Security Disability? No___ Yes ___ Date approved__________

Health Insurance: ☐ None ☐ SSI ☐ Employer/Spouse Employer ☐ Private ☐ COBRA

Patient Employment Status before Breast Cancer:
☐ Full-time ☐ Part-time ☐ Unemployed Last work date:_______________

Monthly Income:_______________

Patient Current Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed ☐ FMLA ☐ Disability/Sick Leave

Receiving Compensation Y/N Monthly Income:_______________

Spouse/Partner Employment Status before Breast Cancer:
☐ Full-time ☐ Part-time ☐ Unemployed Last work date:_______________

Monthly Income:_______________

Spouse/Partner Current Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed ☐ FMLA ☐ Disability/Sick Leave

Receiving Compensation Y/N Monthly Income:_______________

TOTAL HOUSEHOLD INCOME FROM ALL AVENUES:______________________________

Expense	Monthly Amount	Expense	Monthly Amount
Mortgage/Rent		Phone	
Auto Loan 1		Internet	
Auto Loan 2		TV	
Health Insurance		Other	
Utilities		Other	

Please include a complete copy of all bills you would like considered for payment.

Applicants who rent or lease must submit a copy of rental/lease agreement.
Agreement must include payment information.

Physician's Statement

Must be completed and signed by Physician or Nurse Navigator

Patient Name:________________________________ Date: _________________

Date of Breast Cancer Diagnosis:______________ Stage:_________________

Breast Cancer Diagnosis:

____

____

____

Breast Cancer Treatment:

Surgery Date: _______________ Lumpectomy Y/N ________ Mastectomy Y/N _______

Chemotherapy Y/N ________ Start Date:___________ Projected End Date____________

Radiation Y/N ____________ Start Date:___________ Projected End Date_____________

Additional treatments not listed above:

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Signature: ____________________________ Date: ____________________________________

Printed Name __________________________ Title:___________________________________

Email: _______________________________ Phone: ___________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________________, hereby authorize the use or disclosure of protected health information concerning my breast cancer diagnosis and treatment to Joy of Dawn, Inc.

This authorization shall expire in 6 months.

Signature: ____________________________________ Date: ____________________________

Printed Name: ________________________________