joy of dawn
Compassionate. Empowering. Supportive.

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.

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APPLICATION FOR FINANCIAL ASSISTANCE

Name: _____Date of Birth: _____/_____/_____

Street Address: _____ Phone#: _____

City: _____State: _____ Zip: _____County: _____

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: _____

Employer: _____ 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: _____

Employer: _____ 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.

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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:

_____

_____

_____

Signature: _____ Date: _____

Printed Name _____ Title: _____

Email: _____ Phone: _____

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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: _____