



# Thomara Latimer Cancer Foundation

'Helping Families Face The Challenges of Cancer'

## Application for Funds

### **Important: Please Read First!**

The Thomara Latimer Cancer Foundation (TLCF) provides information, financial assistance and emotional support to families affected by any cancer related disorder. TLCF understands that living with this serious illness can be expensive. For this reason, along with fulfilling the legacy of its name's sake, the foundation was created.

TLCF funds are designed to help patients and family members who, after a thorough investigation of other resources, are unable to meet expenses that are causing a financial burden. Expenses addressed by TLCF generally fit into the following categories:

**Provides funds for homecare assistance**

including child care

**Provides funds for medication or treatment not covered by insurance**

including alternative care, expenses that must be paid in order for the patient to get treatment he/she needs such as family lodging for out-of-town treatment and post-lodging

**Provides funds for transportation to and from treatment, physician, support facilities**

including supplement for car repair or car payment

**Special need funds for wigs/head coverings for diagnosis or treatment related to hair loss**

**Provides funds for assistance with final arrangements**

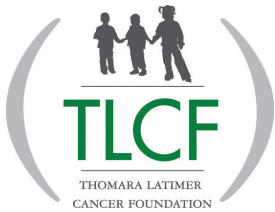
Patients or families should complete the TLCF applications for funds to cover a specific expense. Unfortunately, TLCF is not able to fulfill every request. While TLCF attempts to meet as many needs as possible, some applications may be approved for a grant that is lower than the requested amount, while others may be denied. Much depends on the availability of funds.

**PLEASE NOTE:**

TLCF only accepts applications from residents in the state of Michigan.

Proof of illness must be documented by your oncologist or physician on the physician's, social worker's, or treatment center's letterhead. Documentation may also include copies of invoices from medication, transportation, wigs, homecare, childcare, etc.

Please return the completed form and attachments to TLCF by mail ( Franklin Plaza Center, 29155 Northwestern Hwy #528, Southfield, Michigan 48034) or via website **[www.thomlatimercares.org](http://www.thomlatimercares.org)**. Completed forms with supporting documentation are reviewed in a timely manner. You may be contacted by a member of TLCF's Patient Services department for further discussion about your application. If you have any questions, please call our office at (248) 557-2346.



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## PATIENT INFORMATION FORM

(Please Print or Type)

Date: \_\_\_\_\_

### **PLEASE READ FRONT SHEET BEFORE COMPLETING THIS FORM!**

Child  Adult

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Amount Requested: \$ \_\_\_\_\_ To pay for ... \_\_\_\_\_

Explanation: \_\_\_\_\_

Number in household: Children \_\_\_\_\_ Adults \_\_\_\_\_ Family's Annual income: \$ \_\_\_\_\_

What are the family's *current* sources of income? \_\_\_\_\_

How will the family be able to meet this need in the future? \_\_\_\_\_

Referred by \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Contact person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Daytime phone \_\_\_\_\_ Evening phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### Patient's Health Insurance Information:

Social Worker/health professional helping with case: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Treatment Center: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Health Professional Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### **Medical Insurance Plan**

Name of Insurance Co.: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Does your Insurance pay for any of your treatment Costs? (Y/N): \_\_\_\_\_

Does your insurance pay for any of your prescription costs? (Y/N): \_\_\_\_\_

Is this patient enrolled in MEDICARE? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Pending

Is this patient enrolled in MEDICAID? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Pending

Medicaid Spend Down: \_\_\_\_\_

Other resources researched: Agency: \_\_\_\_\_ Status: \_\_\_\_\_

Agency: \_\_\_\_\_ Status: \_\_\_\_\_

Comments: \_\_\_\_\_

**PLEASE ATTACH SUPPORTING DOCUMENTATION!**