MADDOX J. ALMEIDA
FOUNDATION
(501(c)(3) Non-profit organization)
Supporting families of children with cancer.

PATIENT INFORMATION

Date: _____

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

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

Email Address: _____ Date of birth: _____ ☐ Male ☐ Female

US Citizen: ☐ Yes ☐ No ****Please include Proof of Citizenship***

Name of parent/guardian(s) of the minor: _____ _____

DIAGNOSIS INFORMATION

Date of diagnosis: _____ Primary cancer: _____ Stage: _____

☐ New diagnosis ☐ Recurring Is patient in active treatment? ☐ Yes ☐ No

Please indicate type of treatment(s) received in past twelve months (check all that apply):

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐Hormonal ☐ Palliative Care ☐ Bone marrow/stem cell transplant

☐ Other: _____

HEALTH CARE PROFESSIONAL INFORMATION

MD Name: _____ Hospital/Clinic: _____

Address: _____ City, State, Zip: _____

Phone: ( ) _____

Please include official diagnosis verification letter from physician, with this application.

HEALTH INSURANCE INFORMATION

Does the patient have health insurance coverage? ☐ Yes ☐ No

If yes, please indicate type of insurance (check all that apply): ☐ Private Insurance ☐ Medicaid ☐ Medicare

☐ Other: _____

Are prescription drugs covered by insurance? ☐ Yes ☐ No ☐ Copay

HOUSEHOLD FINANCIAL INFORMATION

Parent or Guardian (s) current employment status? ☐ 1 Parent Employed ☐ Both Parents Employed ☐ Both Parents Unemployed

Parent/Guardian (s) Name: _____

_____ Number of dependents: _____

Parent/Patient Income Sources (please check all that apply):

☐ Social Security ☐ Salary ☐ Pension ☐ Unemployment ☐ Public Assistance ☐ Short-term disability ☐ SSD (Disability) ☐ SSI

☐ Personal Income ☐ Family/friends provide support ☐ Other: _____

Financial Obligations for which the Patient/Parent is requesting assistance:

Mortgage/Rent: $_____ Utilities: $_____ Co-pays $_____
Medications: $_____ Other: Expense: _____ $_____
Expense: _____ $_____
Expense: _____ $_____

Please include receipts/statements for any requested support (e.g.: Mortgage Statement, Receipts, etc.)

Application will not be processed, without copy of driver's license attached and additional information, as required above.

By signing this application, you confirm that all information provided is current and accurate to the best of your knowledge. You also agree that the information provided in this application is subject to verification.

Print Name: _____

I certify that the following attachments are included, with my application:
Please check all that apply

- ☐ Driver's License
- ☐ Latest pay stubs
- ☐ Physician diagnosis verification letter
- ☐ Receipts, statements for any requested support (e.g.: Mortgage Statement)
- ☐ Proof of Citizenship (birth certificate, naturalization certificate, US Passport)

Signature: _____ **Date**: _____

Please include an additional narrative of your circumstances (in the space below) which you would like us to consider, when determining eligibility. (optional)

How did you hear about us? (optional) _____

Incomplete applications will not be accepted.