AVERY FOUNDATION

APPLICATION FOR FINANCIAL ASSISTANCE

Name: _____ Date of Birth: _____
Last (Please Print) First M.I. mm/dd/yyyy

Address: _____
Street Address Apartment / Unit # County

_____
City State Zip Code Email

Home Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact: _____ Emergency Contact Phone: (____) _____
Last Name First Name

Travel Destination for Treatment: _____
Hospital / Clinic Name City State

Treatment Travel Dates	Hotel Stay Needed		**MUST HAVE RECEIPTS** Meals Needed	
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No

Requests for Assistance with other Cancer-Related Expenses:

Medical equipment needed: _____ Purchase Rental

Other assistance needed: _____

Discounted prescription help is available through Hartig Drug.
Is prescription assistance needed? Yes No

If yes, which Hartig Drug location is preferred? _____

Household Income: Verification Required

Gross Income per month: _____ Attach copies of pay stubs for the last 30 days

or

Gross Income per year: _____ Attach copy of most recent tax return

Health Care Provider Verification

Diagnosis: _____

The individual named on the front of this application is under my/our care for cancer-related treatment.

_____ _____

Name of Provider (Please Print) Signature of Provider Date

Assistance is available to residents of the tri-state area in the following counties:

Iowa: Dubuque, Clayton, Delaware, Jackson, Allamakee, Fayette, Jones and Clinton
Illinois: Jo Daviess, Carroll and Stephenson
Wisconsin: Grant, Lafayette and Iowa

Because the assistance provided by the Avery Foundation is determined based on need, income verification is required to ensure that support goes to those most in need of help.

Please attach the following documents to this application:

1. Copies of pay stubs for the last 30 days or a copy of the most recent tax return
2. All dated receipts for hotel stays
3. All meal receipts showing the number of people served and the type of meal consumed (breakfast, lunch, dinner)
4. Receipts for purchased or rented durable medical equipment that is not covered by insurance

Available reimbursement:

1. Mileage: Paid at $0.45 per mile (Mileage determined by MapQuest)
2. Hotel stays: Paid up to $125.00 per night
3. Meals are paid as follows:
    a. Breakfast: Paid up to $7.00 per person
    b. Lunch: Paid up to $10.00 per person
    c. Dinner: Paid up to $15.00 per person
4. Durable medical equipment: Limits may apply.

I UNDERSTAND THAT ALL INFORMATION IS CONFIDENTIAL AND WILL BE MADE AVAILABLE ONLY TO THE AVERY FOUNDATION BOARD OF DIRECTORS AND ITS ASSOCIATED PARTNERS FOR THE SOLE PURPOSE OF DETERMINING INITIAL AND ONGOING ELIGIBILITY FOR ASSISTANCE.

Signature of Applicant: _____

Signature of parent / guardian if under 18 years of age: _____

Date: _____