



# AVERY FOUNDATION

## APPLICATION FOR FINANCIAL ASSISTANCE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ U.S. Veteran \_\_\_\_\_  
Last (PLEASE PRINT) First 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

### Insurance information

Insurance carrier \_\_\_\_\_ Supplemental insurance **YES**\_\_\_ **NO**\_\_\_

Secondary insurance carrier \_\_\_\_\_ Supplemental carrier \_\_\_\_\_

Amount of deductible/out of pocket expense \_\_\_\_\_ (Supplemental=Aflac, Cancer insurance, etc.)

Travel Destination for Treatment: \_\_\_\_\_  
Hospital/Clinic Name City State

**MUST** submit official copy of treatment schedule from the hospital and/or clinic.

If you have lodging expenses, itemized receipts must be submitted. **YES**\_\_\_ **NO**\_\_\_

If you have meal expenses, itemized receipts must be submitted. **YES**\_\_\_ **NO**\_\_\_

### Requests for Assistance with other Cancer-Related Expenses not covered by insurance:

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: \_\_\_\_\_

or

Gross Income per year: \_\_\_\_\_

**MUST** attach copy of last year's 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. A copy of last year's tax return.
2. All dated itemized receipts for hotel stays
3. All itemized meal receipts showing the number of people served and the type of meal consumed (breakfast, lunch, dinner)
4. Itemized 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 \$10.00 per person
  - b. Lunch: Paid up to \$12.50 per person
  - c. Dinner: Paid up to \$20.00 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: \_\_\_\_\_