Madeline Fiadini LoRe Foundation for Cancer Prevention

Application for Financial Assistance
(Please Print)

Today's date:	ID# (**FDN USE ONLY)**

PATIENT INFORMATION

Applicant's Last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name: (Maiden Name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security #:	Home phone : ( )

P.O. Box: City:	State: ZipCode:
Referred to Foundation (please check one box): ❑ Doctor ❑ Hospital ❑ Other: _____ Reason for Assistance: Mamography_____PSA_____Colonoscopy_____	*Preferred Hospital for Screening if approved:* Bayonne Medical Center_____ Jersey City Medical Center_____ Hoboken UMC_____

FINANCIAL INFORMATION

(Documentation regarding Employment Status and most current IRS Income Tax Return may be requested)

Occupation:	Employer:	Employer phone no.:

If unemployed, date of termination of last position held / /	# of people in Household:
Is this patient covered by insurance? ❑ Yes ❑ No	Was the patient ever covered: ❑ Yes ❑ No

If yes, please provide copy of Insurance termination letter.

CERTIFCATION

The above information is true to the best of my knowledge.

Applicant signature: *Date:*

Please mail completed application along with a copy of your prescription to:

MFL Foundation-App., PO Box 34, Bayonne, NJ 07002

FOR FOUNDATION USE ONLY

Date received: _____ Date reviewed:_____ Recommendation Approved:_____ Disapproved:_____

Forwarded to MFL Foundation / /