PCCF

Panhandle **C**ancer **C**ure **F**oundation

Date of Application:______________________________

Name of Applicant:______________________________ Form Completed By: __________________________

Address:______________________________________ Name:____

City, State, Zip:_________________________________ Address:______________________________________

Telephone:_____________________________________ Telephone: ____________________________________

Date of Birth:______________ Age:______________

Healthcare Professional:__________________________ Primary Physician:______________________________

Primary Diagnosis:_______________________________Date of Diagnosis:______________________________

Total amount requested: $_________________.____________

1. How was this amount determined? ____

____

2. Briefly identify the need(s):____

____

____

____

3. Have other resources been explored to meet the identified needs? Yes [ ] No [ ]

If yes, please identify source(s):____

____

____

4. Briefly describe the applicant's situation *(number in household, ages of household members, employment, marital status, etc)*:____

____

____

____

5. How is the applicant's health care paid for? *(Medicare, Medicaid, District Clinic, VA, Insurance, CIDC, Self Pay)*

____

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1000 S. Coulter / Amarillo, TX 79106

806 / 358-8654

6. Identify sources of monthly income and expenses.

Net Monthly Income / Monthly Expenses

Source(s) (18 & older in household)	*Applicant*	*Spouse*	Expenses	*Applicant*	*Spouse*
[ ] Salary/Wages	$	$	Rent/Mortgage-Rent [ ] Own [ ]	$	$
[ ] Pension	$	$	Food Expenses	$	$
[ ] Social Security	$	$	Utilities	$	$
[ ] Supplemental Income (SSI)	$	$	*Heat/Gas*	$	$
[ ] Social Security Disability	$	$	*Electricity*	$	$
[ ] Unemployment Comp.	$	$	*Water*	$	$
[ ] Veteran's Benefits	$	$	*Telephone*	$	$
[ ] Food Stamps	$	$	*Cable*	$	$
[ ] TANF	$	$	Insurance	$	$
[ ] Child Support	$	$	*Life*	$	$
[ ] Savings	$	$	*Property*	$	$
[ ] Stocks	$	$	*Medical*	$	$
[ ] Bonds	$	$	*Auto*	$	$
[ ] CD's	$	$	Installment Debt	$	$
[} Other Income	$	$	Medical Expenses (not covered)	$	$
			Medication(s)	$	$
			Physician and/or Hospital	$	$
			Child Care	$	$
			Other (specify)	$	$
				$	$
Total of Both Incomes	$	$	***Total Expenses***	$	$

1. All information is true and accurate to the best of my knowledge.

2. I give my permission that this form can be shared with the program committee and board of directors if needed.

_______________________________ *Signature*

_______________________________ *Date Signed*

Amount Given_______________________________

Date Given_______________________________

Payee_______________________________

Committee Member_______________________________

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