



Assistance in Healthcare

SOUTHEASTERN

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Please read carefully prior to completing application:

- Only patients currently receiving active cancer treatment will be considered for assistance.
- Please complete the application in full and return by the 10th of each month.
- Applications received after the 10th will be considered for the next month provided you are in active treatment.
- Incomplete applications will not be considered.

Date: _____

Patient's Name: _____ Age: _____

Patient's Phone Number: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Are you currently in active treatment? Yes No If yes, please list last date of treatment _____

If you are in active treatment (i.e. chemo and/or radiation) please list the date of your next scheduled treatment _____

If yes, list name of treatment facility _____

Number of adults living in household: _____ Ages of dependent children in household: _____

Others financially dependent on applicant: _____

Is the patient currently employed: Yes No

Employment Status: Full-time Part-time FMLA/Disability

1. Applicant Employer: _____

Job Title/Position: _____

2. Spouse Employer: _____

Job Title/Position: _____

3. Other Persons: _____

Job Title/Position: _____



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S O U T H E A S T E R N

SOURCES OF INCOME (List MONTHLY amounts):

	APPLICANT	SPOUSE	OTHER PERSONS
Net Wages (after taxes)			
Unemployment			
Sick Pay			
Social Security			
Short/Long term disability			
Retirement Benefits			
Rental Income			
Interest Income			
Alimony			
Child Support			
Trust Funds			
Room/Board			
Welfare			
Military Benefits			
Other			
TOTAL			

EXPENSES (List MONTHLY amounts):

	APPLICANT	SPOUSE	OTHER PERSONS
Rent or Mortgage			
Home Heating (non-electric)			
Electric			
Water, Sewer and Trash			
Home Phone & Cell			
Car Payments			
Car Insurance			
Gasoline			
Food			
Health Insurance			
Life Insurance			
Child Care			
Internet & Cable			

