HEARING THE OVARIAN CANCER WHISPER

H.O.W. Use Only:

Date: _____ Amount Approved: _____

Approved by: _____

Patient Application for Financial Support through the Jacquie Liggett Angel Fund

PLEASE PRINT

Date _____

Name (First, Middle, Last) _____

Address _____

City, State, Zip _____

Phone: _____ Email _____

Date of Birth _____ Social Security _____

Insurance? ☐ Yes ☐ No **HMO?** ☐ Yes ☐ No

Medicare? ☐ Yes ☐ No **Medicaid?** ☐ Yes ☐ Pending ☐ Denied

Monthly Assets

Employer's Name _____

Spouse's Employer's Name _____

Monthly Take Home Pay $_____

Spouse's Monthly Take Home Pay $_____

TOTAL INCOME $_____

Monthly Expenses

Monthly Medical Expenses $_____

(Hospital payments, treatments, insurance, prescriptions, etc)

Monthly Living Expenses $_____

(Rent, mortgage, food, utilities, car expenses, loans, etc)

TOTAL EXPENSES $_____

Specify the type of assistance being requested: (Check One)

☐ Medications ☐ Food/Diet Supplement ☐ Utilities ☐ Transportation

☐ Medical Equipment ☐ Medical Services ☐ Rent/Mortgage ☐ Other

Details of assistance needed _____

_____

_____ Amount $ _____

✓Attach invoices or statements (if applicable) showing expenses. Checks cannot be made payable to the applicant. Please write the name of the vendor and contact information such as rental company, FPL, car insurance, etc.

Check payable to: _____

Vendor Address _____ City _____ ST_____ Zip_____

Telephone Number _____ Account Number _____

Check payable to: _____

Vendor Address _____ City _____ ST_____ Zip_____

Telephone Number _____ Account Number _____

Check payable to: _____

Vendor Address _____ City _____ ST _____ Zip _____

Telephone Number _____ Account Number _____

Physician's or Social Worker's Explanation of Need

The narrative **MUST** include a detailed explanation of the circumstances which require this applicant to request assistance.

Medical Statement

The narrative **MUST** include a detailed explanation of the patient's medical condition(s): _____

✓Complete and attach Patient Authorization for Disclosure of Protected Health Information form.

Verification Signatures

I attest that the information in this application is complete and accurate to the best of my knowledge.

Physician's or ARNP's Signature _____ Social Worker's Signature _____

Physician's or ARNP's Name (print) _____ Social Worker's Name (print) _____

Physician's or ARNP's Phone _____ Social Worker's Phone _____

Physician's or ARNP's Fax _____ Social Worker's Fax _____

Physician's or ARNP's Email _____ Social Worker's Email _____

Facility _____

Address _____ City, State, Zip _____

Send Completed Application and Attachments to:

H.O.W. (Hearing the Ovarian Cancer Whisper)
PO BOX 3504
Jupiter, FL 33469
P: (561) 406-2109
F: (561) 246-4053
E: Jennifer@howflorida.org
W: howflorida.org