Cops 4 Cancer, Inc.
Confidential Application for Assistance

- Cops 4 Cancer, Inc. is a non-profit organization that provides assistance only to individuals in the Illinois Valley (see attached coverage map) area with cancer.
- You will be notified by mail within 60 days as to whether or not your application has been approved.
- Funds are limited and based upon availability and applicant's need, and are in no way based upon race, creed or ethnicity.
- "Assistance" may be in the form of a monetary payment to the applicant, a direct payment to a debtor, a gift certificate for staple items, or the like. Forms of assistance will be decided on a case by case basis by the Cops 4 Cancer Review Committee.
- Approval of this request grants a one-time assistance payment and does not promise future financial assistance.
- All information is held in the strictest confidence and is used only by Cops 4 Cancer, Inc. for the purpose of reviewing financial assistance needs.

PLEASE BE SURE TO:
- Answer each question or indicate if an item does not apply to your situation
- Sign and date the application
- Have your doctor, nurse, or social worker complete the Medical Information section.
- Provide a phone number where you can be reached to answer any additional questions.

Please return this application to:

Cops 4 Cancer, Inc.
ATTN: C4C Review Committee
P.O. Box 1461
La Salle, IL 61301

COPS 4 CANCER, INC.
Application for Assistance

Confidential

PERSONAL INFORMATION

Date: _____

Applicant's Full Name: _____

Date of Birth: _____

Spouse's Full Name (If Applicable): _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

Cell Number: _____

Number of people living in your household? _____Adults _____ Children

Do you rent or own your home? ☐ Rent ☐ Own

Mortgage/Rent Payment? _____

Name & Address of your employer _____

_____

Name & Address of your spouse's employer (if applicable) _____

_____

Do you have health insurance coverage? ☐ Yes ☐ No

Have you previously applied for assistance from Cops 4 Cancer? ☐ Yes ☐ No

COPS 4 CANCER, INC.
Application for Assistance

Confidential

ASSISTANCE ASSESSMENT

For what purpose are you seeking financial assistance?

☐ Housing Costs ☐ Utility Costs ☐ Food Costs ☐ Transportation

Other (Please Explain) _____

If requesting assistance with housing costs, please supply the name and phone number of the Mortgage Provider or Landlord: _____

_____

If requesting assistance with transportation costs, please supply your automobile insurance carrier/agent and phone number: _____

_____

Beyond direct financial support, Cops 4 Cancer would like to make your days less stressful by providing other services. What other services are you interested in?

_____

FINANCIAL INFORMATION

Total Monthly HOUSEHOLD Gross Income: $ _____

Total Household Liquid Assets (Cash on hand, checking/savings, etc.): $_____

Cash on hand (Checking/Savings Accounts, etc.) $_____

Total Monthly Household Expenses: $_____

COPS 4 CANCER, INC.
Application for Assistance

Confidential

MEDICAL INFORMATION
(To be completed ONLY by the Applicant's Doctor, Nurse or Licensed Social Worker)

Primary Cancer: _____ Date of Diagnosis: _____

Is patient active in treatment? ☐ Yes ☐ No

Physician's Name: _____

Hospital/Clinic: _____

Address: _____

_____

Phone: _____ Fax: _____

Signature of doctor, nurse, or social worker: _____

Print Name/Title: _____ Date: _____

BIOGRAPHY

This section provides an opportunity to tell your story. Please use the space below to indicate what your specific circumstances are (duration of your cancer, immediate needs you have, special work/income limitations, etc.)

BIOGRAPHY, Continued

AGREEMENT & SIGNATURE

Please read and sign below after you have carefully reviewed your completed application.

By signing this application, I confirm that I am solely responsible for the accuracy of all information contained herein. I understand that Cops 4 Cancer, Inc. will use any information obtained solely for the purpose of considering financial assistance and that all my medical information will be held in strict confidence. I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release.

Applicant's Signature_____ Date: _____

REMIT APPLICATIONS TO:

Cops 4 Cancer, Inc.
ATTN: C4C Review Committee
P.O. Box 1461
LaSalle, IL 61301