# Direct Patient Assistance Application

**APPLICATION MUST BE SUMBITTED BY A MEDICAL PROFESSIONAL**

**STEP 1 - Completed by LCSW/Patient Navigator/Medical Professional**

Name of LCSW/Medical Professional:______________________________________________

Telephone: ______________________Email: _________________________________________

Date: __________________ Signature of LCSW/Medical Professional:__________________________

*Specific assistance requested:*

☐ *household expense bill – please attach (we cannot process urgent shut-off notices or rent)*

☐ *other (please specify):* ________________________________________________

Patient Name: ___________________________________________ Date of Birth _______________

Patient Address:_________________________________________________________________

Street Apt # City Zip

Patient Preferred Phone: ___________________________ Please circle: Male Female

Name of Oncologist/Specialist:____________________________________________________

Patient Diagnosis:_______________________________________________________________

*What makes this humanitarian grant request a priority?*______________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**STEP 2 – To be completed by the Patient**

**PATIENT PERMISSION (PATIENT MUST SIGN FOR APPLICATION TO BE CONSIDERED COMPLETE)**

*Cancer Care Foundation of Tidewater (CCFOT) is a nonprofit organization chartered by the Commonwealth of Virginia. We will act on your behalf for limited financial aid, information and assistance.* I, ___________________________(print name), according to the Privacy Acts legislated for the confidentiality and privacy of my health information, do hearby permit release of my information for this foundation and cognate agencies that may be contacted in discussing my non-medical needs. Please sign/date to signify permission to release information to CCFOT.

Patient Signature:_______________________________________________Date:____________________

**Submit applications *BY EMAIL ONLY TO CCFOTIDEWATER@GMAIL.COM.* Please allow up to 2 weeks for email notification of disposition of complete grant applications. We rely on LCSW to communicate with patients. *Please do not instruct patients to call our office.* Thank you.**