JERRY RUBIN FOUNDATION PATIENT ASSISTANCE PROGRAM

Please print clearly. Attach additional pages if necessary, including copy of bills, as applicable.

APPLICANT INFORMATION

LAST NAME FIRST NAME DATE OF BIRTH

MAILING ADDRESS CITY STATE ZIP

EMAIL ADDRESS PHONE ALTERNATE PHONE

CONTACT PERSON IF UNABLE TO REACH YOU CONTACT PHONE

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

OF PERSONS IN HOUSEHOLD AGES OF CHILDREN

EMPLOYED? ☐ YES ☐ NO IF YES, EMPLOYER

HEALTH INSURANCE? ☐ YES ☐ NO INSURANCE PROVIDER?

PHYSICIAN PROVIDING TREATMENT MEDICAL TREATMENT FACILITY

REFERRED TO HOSPICE? ☐ YES ☐ NO HOSPICE AGENCY

Completed applications and attachments can be mailed/delivered to Pacific Cancer Care, ATTN: Valeria Wareham. 5 Harris Court, Building T, Suite 201, Monterey, CA 93940. Or, email a scanned copy of application and attachments to **vwareham@jerryrubinfoundationforcancercare.org**

FINANCIAL INFORMATION

MONTHLY HOUSEHOLD INCOME?
(include wages, unemployment, retirement income, social security, disability, alimony, child support etc.)

$________________

APPROXIMATE MONTHLY EXPENSES?
(include rent/mortgage, auto payment, insurance, utilities, phone, food etc.)

$________________

FINANCIAL ASSISTANCE NEEDED FOR:

- ☐ GROCERIES
- ☐ RENT/MORTGAGE
- ☐ UTILITIES
- ☐ TRANSPORTATION
- ☐ GAS
- ☐ CHILD CARE
- ☐ PHONE
- ☐ OTHER

AMOUNT REQUESTED **$**________________

SIGN/DATE

INTERNAL USE ONLY

DATE RCD ____________ BOARD RVW ____________

BOARD APPD AMT____________ ISSUED____________