Patient Financial Assistance Application

Pennies with Purpose

Patient Name:		**Date:**
Patient Address:		
City:	**State:**	**Zip Code:**
Telephone:	**Date of Birth (MM/DD/YY):**	
Email Address:		

Requested Service or Item	**Approximate value: $_____**

1. *Is patient currently undergoing cancer related treatment? (CIRCLE YES or NO)

   Radiation? Yes No Chemo? Yes No Surgery? Yes No

   *If patient is NOT currently undergoing one of these treatments, has patient received one of the above treatments with in the last 18 months? Yes or No Date of last treatment:_____

2. Total Gross Annual Household Income*: $ Number of Persons in household:
   (include yourself and those you are financially responsible for)

   **Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Other Income*

3. (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE PWP TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFIED.

Patient or Responsible Party Name (Print): _____

Patient or Responsible Party Signature: _____

Name of Facility _____

Social Worker /Health Care Professional Name (Print) _____ ***Signature*** _____

Please return this form by Email, or mail.

Email–info@pennieswithpurpose.org
or
Mail to:Pennies with Purpose

167 Iveydale Road Mableton, GA 30126

Questions please call–770-693-5929

Please circle below how you would like to receive your grant.

Zelle
Cash-App
Gift Card