# Application for Financial Assistance

*If you or a loved one have been diagnosed with leukemia and need financial assistance, please complete and return this form to:*

**The Perillo-Stafford Leukemia Foundation, Inc.**
**17633 Gunn Hwy, Ste 174**
**Odessa, FL 33556**

Please remember to ask your healthcare provider to complete and sign the box at the bottom of the page. This information is confidential.

Patient First and Last Name: _____
If patient is less than 18 years old please provide
Parent/Guardian First and Last Name: _____
Address City/State/Zip: _____
Home Phone (  )_____ Work or Cell Phone (  ) _____
Email: _____ Website: _____

**Patient Information**
Gender: ___ Male ___ Female Date of Birth: _____ Date of Diagnosis: _____
Ethnicity: ___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other
Do you have health insurance? ___ Yes ___ No
Do you have Medicare? ___ Yes ___ No Do you have Medicaid? ___ Yes ___ No
Would you like to list another person for us to contact on your behalf? If so,
First and Last Name: _____
Phone (if different than above): (  )_____ Email: _____
Relationship to patient (check all that apply):
____ Caregiver ___ Spouse/Domestic Partner ___ Parent ___ Child ___ Sibling ___ Friend/Concerned Individual ___ Other
Briefly explain your financial situation and why a donation would be of benefit:
_____
_____
_____

**Patient/Parent Signature: _____ Date: _____**
**Thank you. We will be in contact with you soon about your application. Should you have any questions, you can contact Joe Perillo @ 813-244-7083.**

**– To be completed by patient's doctor, nurse or social worker –**
Patient Diagnosis: _____
Is Patient In Active Treatment? ___ Yes ___ No
Provider Name Hospital/Clinic: _____
Address City/State/Zip: _____
Phone: (  )_____

**Provider Signature:** _____ **Date**: _____
Note: ___ Physician ___ Nurse ___ Social Worker