

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