KENNY CAN FOUNDATION FOR BRAIN CANCER

PATIENT INFORMATION

Enclosed is the patient application for the Kenny Can Foundation For Brain Cancer. For this application to be considered, the application must be completed in its entirety**.**

The mission of the Kenny Can Foundation For Brain Cancer is to raise And allocate funds dedicated to research the causes and cures Of brain cancer as well as to aid victims who have been Affected by this deadly disease.

For more information please visit our website at ***www.kennycan.org***

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY
(All information will be strictly confidential)

Patient Name ____ Date of Birth ___________

Social Security ____ US Citizen (Y) (N)

Address ____

City ____State __________ Zip _______

How long did you reside at the above address? ___________________________________

Home Phone # (_____)___________________ Work Phone # (_____)_______________

Patient Employer ___________________________________ How long have you been employed at this job? _______

Address ____

City ____ State _______________ Zip ______

Spouse (name) ____

Spouse Employer ____

Address ____

City ____ State _______________ Zip ______

Applicant Signature __________________________________ Date ___________________

If MINOR

Parent's Name or Legal Guardian __________________________ SS# _______________

Home Address ____

Home Phone # (______)______________________ Work Phone # (______)__________

Employer ____

Address____

City ____ State _____________ Zip _______

How long did you reside at the above address? _________________________________

(All information will be strictly confidential)

How did you learn about the Kenny Can Foundation?

____

____

INSURANCE INFORMATION

Insured Person ____

Insurance Company ___________________________________Phone # (______)__________

Employer (if group coverage) ____

Policy # ______________________________________ ID #___________ Group # _________

Additional Information ____

2nd Insurance Company _______________________________ Phone # (_____)___________

Explain why Insurance is not paying ____

- **Have you applied for financial aid through other organizations? Circle one. Yes No**

  If so, Where?

- **Were you denied? Circle One. Yes No**

  Please write specific details and show proof of denial on a separate sheet of paper and attach.

DEPENDENT CHILDREN

Child (1) ____Age________________________

Child (2) ____Age________________________

Child (3) ____Age________________________

Child (4) ____Age________________________

Child (5) ____Age________________________

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(All information will be strictly confidential)

INCOME AND EXPENSES REPORT

1. **Is there any agreement specifying a contribution for a contribution for this patient's medical expenses by anyone else? Circle One. Yes No**
   If yes, by whom and how much? _______________________$___________

2. **Please send copies of your last two years IRS Federal and State Tax Returns. How many children, including the applicant(s) are residing in your home and/or receiving support from you? __________**

3. **Fill in the blanks below with the required information.**

FEDERAL INCOME TAX FILING STATUS:

Last Year

- ❑ Single
- ❑ Married, filing jointly
- ❑ Married, filing separately
- ❑ Head of Household

FEDERAL INCOME TAX FILING STATUS:

This Year

- ❑ Single
- ❑ Married, filing jointly
- ❑ Married, filing separately
- ❑ Head of Household

ADDITIONAL INFORMATION
Unusual expenses: such as severe medical expenses, death, etc. Please describe in detail on a separate sheet of paper and attach.

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(All information will be strictly confidential)

IN YOUR OWN WORDS, PLEASE WRITE A LETTER EXPLAINING WHAT A DIFFERENCE RECEIVING FINANCIAL AID WILL MAKE IN YOUR LIFE AND WHY YOU ARE IN NEED OF FINANCIAL AID.

ADDITIONALLY PLEASE HAVE YOUR PHYSICIAN PROVIDE THE FOLLOWING INFORMATION.

MEDICAL HISTORY

Attending Physician

Doctor Information

Diagnosis

Date of Diagnosis

Medial Treatment To Date

Planned Medical Treatment

Other Treatment Considered

Other Treatment Declined/Denied

Prognosis