Please return completed application to:

LCGH Fund for Hope

Lewis County Hospital Foundation

7785 North State Street

Lowville, NY 13367

Email:**fundforhope@lcgh.net**

Phone: 315-376-5493

Fax: 315-376-9317 **CONFIDENTIAL APPLICATION**

**SECTION** **1: PATIENT INFORMATION**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you a resident of Lewis County or do you use the services of Lewis County General Hospital?

Circle one: Yes No If you circled no, you do not qualify for the Fund for Hope.

How did you learn about the Fund for Hope? Social Worker \_\_\_ Word of Mouth\_\_\_ Clinic or Doctor\_\_\_ Cancer Services Programs \_\_\_ Hospital/Foundation Website \_\_\_ Hospital Foundation facebook page\_\_\_

**SECTION 2: CANCER TREATING PHYSICIAN INFORMATION**

Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

I HAVE CONTACTED THE LCGH FUND FOR HOPE FOR TRAVEL ASSISTANCE AND HEREBY AUTHORIZE MY DOCTOR TO RELEASE INFORMATION REGARDING MY (OR MY CHILD'S) ILLNESS AND TREATMENT TO THE LCGH FUND FOR HOPE. I AM SUBMITTING THIS APPLICATION FOR TRAVEL ASSISTANCE DUE TO THE FINANCIAL BURDEN INCURRED AS A RESULT OF CANCER*.*

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Must be signed by the patient***

**SECTION 3: TO BE COMPLETED BY CANCER TREATING PHYSICIAN**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Dx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note: The cancer treating physician section must be completely filled out to be considered for funding.***

For office use only-Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_