We're here for you!

Foundation of Onvida Health

PEDIATRIC ONCOLOGY SUPPORT FUND

Helping families when they need us the most

The objective of the Pediatric Oncology Support Fund at the Foundation of Onvida Health is to provide financial assistance to deserving families of children in Yuma County battling cancer. The Foundation of Onvida Health provides grants annually to minimize the financial hardships that is directly attributable to the child's illness.

We will not, in any circumstances, share your personal information with other individuals or organizations without your permission, including public organizations, corporations, or individuals, except when applicable by law.

(To be completed by patient or healthcare decision maker – You can type directly in to this document. If you submit a completely hand-written application, PLEASE PRINT.)

Patient Name: _____ DOB: _____ Gender: _____

(Information will be used for statistical purposes only and will not affect eligibility.)

Ethnicity: African-American_____ Asian/Pacific Islander_____ Caucasian_____ Hispanic_____

Native American_____ Other _____ Prefer not to answer_____

Parent/Legal Guardian Name: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip Code: _____

Household information

Annual Household Income:

- o Less than $20,000
- o $20,000-$35,000
- o $35,000-$50,000
- o $50,000-$75,000
- o $75,000-$100,000
- o $100,000-$125,000
- o $125,000-$150,000
- o $150,000-$175,000
- o $175,000 or more

Number of household members: _____ Number in school:_____

Please include proof of income documents with your application. Acceptable documents may include:

- The first two pages of signed income tax return (you may blacken out your social security number)
- If you do not file a tax return, you may submit a copy of your most recent pay stub, unemployment check, or SSI, SSD, or public assistance benefit notification
- If you do not have any income, provide a letter of support from friend or family member

Please include additional information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

_____

_____

Intended use of grant (please provide bills paid directly to the creditor with the creditor name, account number, mailing address, family's last name, and dollar amount owed):

_____

_____

_____

_____

Medical Information Form

(This section to be completed by health care provider or social worker. You can type directly in to this document. If you submit a completely hand-written application, PLEASE PRINT)

Patient Name: _____

Patient Diagnosis: _____

Date of Diagnosis (Month-Day-Year): _____

Patient Physician: _____

Hospital: _____

Address: _____

City: State: Zip Code: _____

Health Care/Social Worker's name: _____

Health Care/Social Worker's agency: _____

Health Care/Social Worker's Direct Phone Number and Extension: _____

Health Care/Social Worker Email: _____

Please describe the patient's medical condition, anticipated hospital stay, and any other notable facts (please attach a letter if needed): _____

_____

_____

_____

_____

_____

Health Care/Social Worker's Hand-Written Signature: _____ Date: _____

Agreement

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance. Additionally, you are giving your medical team permission to share medical information about your child. Incomplete applications will be returned to you.

By signing this application, you agree to allow publication of patient name and medical condition by the Foundation of Onvida Health and its affiliates.

☐ *Opt out*

Signature of Patient: _____ Date: _____

Signature of Legal
Healthcare Decision Maker: _____ Date: _____

Contact us!

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