Connie RUTLEDGE LEGACY FUND

Fulfilling Ovarian Cancer communities needs through a partnership with the Wisconsin Ovarian Cancer Alliance

Financial Request Form

The Connie Rutledge Legacy Fund (CRLF) was founded to assist those impacted by ovarian and other gynecological cancers as well as ovarian cancer research. CRLF assists individuals regardless of age, gender, race, religion or sexual orientation.

To be eligible for financial assistance you must be undergoing treatment for ovarian or other gynecological cancer. All recipients need to be a resident of Wisconsin. Applicant's income restriction is 250% or less of federal poverty levels and/or whose insurance/Medicare assistance is not sufficient for applicant to maintain financial stability.

Please complete the request form and mail to the WOCA office: 13825 W. National Ave, Suite 103, New Berlin, WI 53151 or email to Jennifer@wisconsinovariancancer.org.

Please complete the following section about the applicant:

Applicants Name: _____ Date of Birth_____

Address_____City_____Zip_____

Phone #_____ E-Mail_____

Person Completing This Form_____ Relationship to Applicant_____

Household income/financial status including disability income_____

Number in Household_____

Please have the following section completed by the physician overseeing the applicant's treatment:

(Name) _____ is a patient of mine and currently receiving treatment for cancer.

Doctor's Name (please print) _____ Phone #_____

Doctor's Signature_____ Date _____

Email Address_____

Location(s) of treatment (hospital and city)_____

Type and Stage of Cancer_____
Date of Diagnosis _____

The Connie Rutledge Legacy Fund & The Wisconsin Ovarian Cancer Alliance bear no responsibility on patient's treatment options or decisions.

This section to be completed by patient or representative.

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Copies of bills/receipts must accompany this request. **If bills are not included the application will not be accepted.**
Unfortunately checks CANNOT be made out directly to the requestor.

If approved, WOCA, will send the check to you made payable to bill recipient. It is your responsibility to distribute the checks to the recipient(s). **Recipient is limited up to $1000 annually per submission date**.

Request _____ Amount requested _____

- ☐ Rent
- ☐ Utilities
- ☐ Daycare/Home assistance
- ☐ Transportation/lodging
- ☐ Physician fees
- ☐ Diagnostic fees
- ☐ Hospital expenses
- ☐ Medications
- ☐ Phone
- ☐ Other_____

Please List all Bill Recipients & Amounts

Name: _____ Amount: _____

Name: _____ Amount: _____

Name: _____ Amount: _____

Name: _____ Amount: _____

☐ Please check here if you have received assistance from the CRLF or WOCA in the past.

If so, Amount_____ and Date_____

Please add any other information that would be relevant to this application:

_____

If chosen, would you be willing to share your story/ experience with other? _____

Preferred method of being contacted? _____

May a WOCA representative contact you? _____

I certify that the information provided in this application is true and accurate. I understand that withholding or falsifying any information in this application will disqualify me from any assistance from **the Connie Rutledge Legacy Fund** now or in the future.

Signature _____ Date _____
Please indicate if: ☐ Patient or ☐ Representative

PLEASE REMEMBER TO ATTACH YOUR BILLS FOR PAYMENT

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www.wisconsinovariancancer.org