**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.kerber@wisconsinovaraincancer.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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information relevant to this request\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This section to be completed by patient or representative.

**Copies of bills/receipts must accompany this request.** Unfortunately checks **CANNOT** be made out directly to the requestor.

Request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount requested \_\_\_\_\_\_\_\_Check payable to\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Utilities

Physician fees

Medications

Daycare/Home assistance

Diagnostic fees

Personal assistive devices

Rent

Transportation/lodging

Hospital expenses

Wigs, head coverings

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Total Amount Requested**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 If so, Amount\_\_\_\_\_\_\_\_\_\_\_\_ and Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

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**

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