Wyoming Foundation for Cancer Care
441 Landmark Dr. Ste 300
Casper, WY 82609
admin@wyofcc.org
www.wyofcc.org
307-262-0749

# APPLICATION CHECKLIST

Please submit the requested information below
Incomplete applications will not be accepted

1. Financial Assistance Application Sheet
2. Current Wyoming Driver's License or State Issued I.D.
3. Oncology Clinic Office Note(s) from treating oncologist that states your current treatment plan – Clinic notes must be less than 30 days old. Please be aware that a letter from your oncologist will not suffice.
4. Copies of the bills you would like assistance with – Must be less than 30 days old
5. If applying for lodging assistance – please include hotel name, phone number, hotel confirmation number and dates of stay. Please book directly through the hotel.

   Hotel Name: ______________________________________________
   Hotel Address: ____________________________________________
   Hotel Phone Number: _______________________________________
   Hotel Confirmation #: ______________________________________
   Reservation Dates: _________________________________________

6. If requesting gas money – please include vehicle type, roundtrip mileage (from home to treatment center) and how many trips will be made.

   Vehicle Type: _____________________________________________
   Round Trip Mileage: ________________________________________
   Dates: ___________________________________________________

**Please email all requested information to**
admin@wyofcc.org
**OR**
mail to
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# FINANCIAL ASSISTANCE APPLICATION

**PLEASE FILL IN ALL BLANKS**

Amount Approved Prior: $______________________________
Legal Name: ________________________________________ DOB: _______________ Gender: ___________
Ethnicity: __________________________ Phone #: (_______)________________________________________
Mailing Address: ______________________________________________________________________________
__________________________________ City:______________________________ Zip Code: ______________
Employer: _______________________________________________________________ (N/A if not applicable)
Cancer Type: _________________________________________________________________________________
Treatment Facility: ___________________________________ City: __________________ State: ___________
Physician(s): _________________________________________________________________________________
Insurance Provider(s): ________________________________________________ (N/A if not applicable)

## Funding Category Requested – Please Check All That Apply:

Car Expense (car payment, insurance, etc.) Provide bill info below.
Housing (Rent, Mortgage, Insurance, etc.) Provide bill info below.
Food/Groceries (please include requested amount)
Travel/gas provide requested amount below (please include roundtrip mileage and dates)
Lodging (**please include hotel info, hotel confirmation and reservation dates**)
Angel Wig Product(s) **OR** Angel Breast Boutique Product(s)
Misc/Other: _________________________________________________

Amount: $ _________________________ Company/Name: _________________________________
Amount: $ _________________________ Company/Name: _________________________________
Amount: $ _________________________ Company/Name: _________________________________
Amount: $ _________________________ Company/Name: _________________________________

**Total Amount Requested: $** _______________________________ (Must not exceed $1,000)

Name of Individual Submitting Application: _____________________________________________________

**Please carefully review the following statements and sign below to indicate your agreement with the terms outlined.**

- *I understand that Wyoming Foundation for Cancer (WFCC) does not provide emergency funding.*
- *I understand that WFCC will not reimburse previously paid expenses, and all bills submitted must be current (within 30 days).*
- *I understand that if requesting lodging assistance, I am responsible for choosing my hotel and making my own reservation and providing hotel information, confirmation number & reservation dates to WFCC.*
- *I understand that WFCC will not accept Airbnb for lodging OR reservations made through 3rd party agencies (Kayak, Expedia, Priceline, etc.)*
- *I understand that WFCC will not accept incomplete applications (please reference checklist).*
- *I understand that WFCC may assist up to $1,000 per patient, per year, however, application submission does not guarantee funds.*

**Patient/Guardian Signature:** _____________________________________________ **Date:**

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**For Foundation Use Only**

Patient #: _________ Request #: _________ Date of Review #: _________ Check #_________

**APPROVED** **DENIED**

Reason for Denial: ___________________________________________________________________________
Emily Walsh, Office Coordinator: ________________________________________ Date: _______________
Tish Chase, Executive Director: __________________________________________ Date: ________________