Arizona Assistance in Healthcare (AAHC) helps patients defray non-medical expenses when actively receiving cancer treatment. AAHC is supported through fundraising efforts of its members and donations.

A few things you should know: (Please read carefully)

1. The AAHC Application Committee typically reviews submitted applications on the second Friday of every month.
2. Present your **completed** application to your care provider at the time of your visit for the physician certification portion of the application.
3. Mail your application to: Assistance In Healthcare, Inc.
   P.O. Box 5157
   Goodyear, Arizona 85338
4. To allow enough time to review, process and copy your application, the AHHC Application Committee must have it by the end of business on the last day of every month. Late applications will be treated as LATE and will not be able to be processed for that month.
5. You must have received treatment at a Phoenix area medical facility **within the last 30 days** to be eligible to apply for assistance.
6. The committee will accept only one application per patient each month.
7. Please ensure the entire application form is completed including the “How this will help you” section on page 3. Incomplete forms will not be considered.
8. Each request is reviewed individually.
9. The amount of assistance granted will depend on the amount of funds available and the financial status of the applicant, not exceed $250. *Checks will need to be cashed within 90 days of issue. Checks older than 90 days are voided and will not be reissued.*
10. Applying **does not guarantee you will receive funds.**
11. The information you provide on your application is kept in the strictest confidence. Please allow us the same courtesy with regards to the amount of funds provided to you and refrain from informing others.
12. **Arizona Assistance in Health Care cannot assist you with any doctor bill, hospital bill, insurance premium, prescription, hotels, travel, or other medical expenses.**
13. Address any question regarding your application via email info@AzAssistanceinHealthcare.com

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED*
APPLICATIONS MUST BE RECEIVED BY THE LAST DAY OF EACH MONTH FOR CONSIDERATION THE FOLLOWING MONTH.

Original Applications must be submitted each month
Please note, previous applications and photocopies will not be accepted

Today's Date: _____

Patient's Name: _____ Age: _____

Applicant's Phone number: (_____)_____ Applicant's **SS#**:_____

Applicant's Address: _____

City: _____ State: _____ Zip: _____

Cancer Diagnosis and condition of patient: _____

_____

No. living in household: _____ Ages of dependent children in household: _____

Others financially dependent on applicant: _____

Is the patient currently:

- □ Employed and working full-time
- □ Employed and working part-time
- □ Employed but on FMLA/Disability/Leave
- □ Unemployed
- □ Disabled

	APPLICANT	SPOUSE	OTHER PERSONS
Employer			
Type of Work			

ASSETS (List **CURRENT VALUE**):

Checking Accounts	$		
Savings Accounts	$		
Other Investments/ Liquid Accts	$		

SOURCES OF INCOME (**List MONTHLY amounts**):

	APPLICANT	SPOUSE	OTHER PERSONS
Net Wages **(after taxes)**			
Unemployment			
Sick Pay			
Social Security			
Short/Long term disability			
Retirement Benefits			
Rental Income			
Investment Income			
Interest Income			
Alimony			
Child Support			
Trust Funds			
Room/Board			
Welfare			
Military Benefits			
Other:			
TOTAL			

EXPENSES (List **MONTHLY** amounts):

Rent or Mortgage			
Gas			
Electric			
Sewer and Water			
Telephone & Cell			
Car Payments			
Car Insurance			
Gasoline and Oil			
Food			
Health Insurance			
Life Insurance			
Medications			
Prescribed Vitamins			
Child Care			
***Other Debts (**payments**)			
TOTAL			

***OTHER DEBTS (i.e., credit cards, medical bills, loans, etc.) List **FULL BALANCES**

By my signature, I certify that all information provided is complete and accurate to the best of my knowledge. I understand that Arizona Assistance in Healthcare, Inc. ("AAHC") is not required to render any assistance to me and that I will remain responsible for payment of all bills. By accepting this application, AAHC has assumed no responsibility for payment of any bills.

Applicant's Name Printed

Applicant's Signature (Signature cannot be DocuSign)

~~All information must be complete to process your application~~

~Only patients currently undergoing cancer treatment in the Phoenix Metropolitan Area will be considered for assistance~

Please return application to:
Arizona Assistance in Health Care, Inc.
P.O. Box 5157
Goodyear, AZ 85338

Please let us know how this will help you and be as specific as possible as to why you need this grant, specifying food, rent or other non-medical emergency needs:

□ **Utilities** □ **Credit Card Debt** □ **Rent** □ **Food**
□ **Other** _____

Note: Arizona Assistance in Health Care, Inc. cannot assist with payment of Hospital Bills, Doctor Bills, Medication Expenses, Travel Expenses, and/or Lodging Expenses.

Story: (MUST INCLUDE WHAT THE FUNDS WILL BE USED FOR)

□ I am willing to share my story. *(Financial information will NOT be shared)*

Please Provide Email_____

PATIENT AUTHORIZATION

I hereby authorize the physician(s) or physician groups noted below to verify my status as a cancer patient, my diagnosis, and to discuss the anticipated duration of my treatment with Arizona Assistance in Healthcare, Inc. and its representatives.

Patient Name:_____

Home Phone:_____

Physician Name:_____

Office Address:_____

Office Telephone Number:_____

Office Email for Patient Verification: _____

Patient Signature:_____**date:**_____

(This section for physician/clinician only)

PHYSICIAN CERTIFICATION

I certify that _____ (patient name) is being *ACTIVELY (not maintenance)* treated for _____(cancer-related diagnosis).

Treatment type: (please check all that apply)

_____ **IV Chemotherapy** _____ **Surgery: Date: _____**
_____ **Oral Chemotherapy** _____ **Radiation Therapy**
_____ **Other** _____

The patient is expected to be under active treatment for _____ (time frame).

Applications without a time frame will not be considered.

_____ _____

Physician Signature (Signature can not be DocuSign) **Date**
(must be physician signature – cannot be stamped or nurse signature)
(physician signature and date must be within last 60 days)

Physician Name (printed): _____