a woman like you®
FOUNDATION

www.awomanlikeyou.org

Application for Assistance

A Woman Like You Foundation is a non profit organization, which is dedicated to assisting residents of the Louisville, Kentucky area who are battling cancer, and who lack sufficient health insurance and/or financial resources.

Send completed application to:

A Woman Like You Foundationof Kentuckiana, LLC
Louisville, KY

If you have questions, contact us at

(502) 608-7761 or (502) 802-3500

IMPORTANT!
You must sign the releases on page 4 & 5
before sending us this application.

All information is strictly confidential.

A Woman Like You Foundation of Kentuckiana, LLC
Application for Assistance

For Office use only
Date Rec'd: _____
File No: _____

NOTE: All information will be kept strictly confidential.

Application Date: _____

Applicant's Name: _____

Age: _____ Date of Birth: _____ Male ___ Female ___

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Telephone Number: _____

Physical Address if different from mailing address:

City: _____ State: _____ Zip:_____

Telephone Number: _____

ILLNESS

Diagnosis: _____

Date Diagnosed: _____

General Prognosis:_____

MEDICAL CONTACTS
The following information is necessary, so that we may verify your condition:

	Physician	Social Worker
Name		
Address		
Phone		

INSURANCE
If Applicant has Health Insurance, Medicare, or Medicaid please specify _____
_____
_____
_____
_____

SOURCES OF INCOME

The following financial information is used to determine applicant's need for help. It will be shown only to the Board of Directors of A Woman Like You Foundation of Kentukiana, LLC and will not be divulged to anyone else. Additional information may be requested at the discretion of A Woman Like You Foundation of Kentuckiana, LLC Board of Directors.

How many people are currently living in your household?_____

List current sources of income for yourself and for other members of your household:

	Applicant	**Spouse/Other Household Members**
Wages	**$**	**$**
Social Security	**$**	**$**
Disability Income	**$**	**$**
Other $ $		
Total Income per Year	**$**	**$**

RESIDENCE

Do you or your family OWN _____ or RENT _____ the home in which you are living?

If owned, what is its present value? $_____ What is the current mortgage? $ _____

OTHER ASSISTANCE FOR WHICH APPLICANT HAS APPLIED

If applicable, describe the following assistance, for which you have applied:

1. Health Insurance (list insurer) _____
2. Medicare/Medicaid _____
3. Fuel assistance, Social Security Disability, aid from the Town Welfare Office, aid from the Veteran's Administration _____
4. Other _____

Please mention any other facts you would like us to consider while discussing your request

_____

ASSISTANCE OR RESOURCES REQUIRED

List the types of financial assistance or resources you require (Note: we cannot pay for medical expenses): _____

If someone other than the applicant is submitting this application, please complete the following:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Relation: _____

Name and contact information of person A Woman Like You Foudation of Kentuckiana, LLC should contact if we have questions concerning arrangements for distributing funds:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Relation: _____

General Release

I/We wish to participate in the benefits provided by A Woman Like You Foundation of Kentuckiana, LLC, Louisville, KY.

I/We understand that our participation in such a program is wholly voluntary and that these benefits are provided by A Woman Like You Foundation of Kentuckiana, LLC in furtherance of its humanitarian endeavor to provide financial support to Louisville, Kentucky area residents who are battling cancer without the assistance of health insurance and/or who are in financial difficulties.

I/We hereby assume all risks and responsibility for any damage or injury (including the aggravation of any existing illness or condition), which we or our family may sustain as a result of our participation in the benefits provided by A Woman Like You Foundation of Kentuckiana, LLC, its officers, directors, board, agents, sponsors, medical advisors, volunteers, and employees.

I/We hereby release, discharge, indemnify and agree to hold harmless A Woman Like You Foundation of Kentuckiana, LLC, its officers, board, directors, agents, sponsors, medical advisors, volunteers, and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, r esulting from, arising out of, or incidental to our participation in the programs or benefits provided by A Woman Like You Foundation of Kentuckiana, LLC.

In Witness thereof this _____ day of _____, Year _____

Signed: _____ Witness: _____

Authority to Release Hospital Records and/or Divulge Medical Information

1. PRIMARY CARE PHYSICIAN/HOSPITAL

_____

Address: _____

In regard to your patient named: _____ **Age:** _____ **DOB:** _____

You are hereby authorized to furnish and release to A Woman Like You Foundation of Kentuckiana, LLC* all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ **Date:** _____
Patient (or adult with authority to act for minor)

Witness: _____ **Date:** _____

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2. ONCOLOGIST/HOSPITAL_____

Address: _____

In regard to your patient named: _____ **Age:** _____ **DOB:** _____

You are hereby authorized to furnish and release to A Woman Like You Foundation of Kentuckiana, LLC* all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ **Date:** _____
Patient (or adult with authority to act for minor)

Witness: _____ **Date:** _____

3.OTHER/HOSPITAL:_____

Address: _____

In regard to your patient named: _____ **Age:** _____ **DOB:** _____

You are hereby authorized to furnish and release to A Woman Like You Foundation of Kentuckiana, LLC* all information and records requested (regarding findings, treatment rendered, and opinions) as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Signed: _____ **Date:** _____
Patient (or adult with authority to act for minor)

Witness: _____ **Date:** _____

*A Woman Like You Foundation of Kentuckiana, LLC is a non-profit organization, which provides non-medical supplemental financial assistance to cancer patients in the Louisville, KY area.