APPLICATION FOR FINANCIAL ASSISTANCE

FOUNDATION

Application information

Name:	Date of Birth:	MM/DD/YYYY	_ US Veteran:		
Address:					
Street Address Apartment/Unit # County					
City State			Zip Code		
Home Phone:	Cell Phone:				
Parent/Guardian	_ Email:				
Insurance information					
Insurance carrier:		Supplemental ir	surance YES	NO	
Secondary insurance carrier:		Supplemental carrier:			
Amount of deductible/out of pocket expense:		(Supplemental=Aflac, cancer insurance, etc.)			
Clinic/Hospital					
Destination for treatment:	City		State		
			State		
Secondary destination: Clinic or Hospital	City		State		
MUST submit an official copy of your treatment and appointment schedule. If you have lodging expenses, itemized receipts MUST be submitted. YES NO					
If you have meal expenses, itemized receipts <u>MUST</u> be submitted. YES NO					
Request for assistance with other cancer related expenses not covered by insurance					
Medical equipment needed:			Purchase	Rent	
Other assistance needed:					
A discounted prescription drug program is available for Avery letter from Hartig Drug within 30 days of your application beir Program to your favorite Hartig Drug Pharmacy.				eceive a	



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NEW for 2024! Reimbursement for cancer survivorship fitness programs



Volv Fitness, located at 340 E. 12th St. Dubuque, is offering special programs for cancer survivors. Through clinical exercise as a form of rehabilitation, Volv Survivorship is dedicated to supporting cancer survivors during their treatment and remission. It is their goal to help survivors improve their quality of life, daily function, and all aspects of brain health while supporting positive behavior change that we hope will last a lifetime. Please contact Volv Fitness and the Crocus Foundation for more information

Volvfitness.com/programs/survivorship/

563-556-6496

crocusfoundation.com

Volv Survivorship is an approved provider of services for the Avery Foundation. The Avery Foundation may reimburse any amount that the Crocus Foundation does not cover. Itemized receipts must be submitted with application.

Household income

Gross income per month:_____

Gross Income per year:_____

MUST submit a copy of last year's tax return.

Health care provider verification

Cancer diagnosis:___

The individual named on page 1 of this application is under my/our care for cancer-related treatment.

PROVIDER				
Name: Please print	Signature:	Date:		
Assistance is available to residents of the Tri-States in the following counties:				
Iowa: Allamakee, Clayton, Clinton, Delaware, Dubuque, Fayette, Jackson and Jones				
Illinois: Carroll, Jo Daviess and Stephenson				
Wisconsin: Grant, Iowa and Lafaye	tte			



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Please attach the following documents to this application:

- 1. A copy of last year's tax return.
- 2. All dated and itemized receipts for lodging.
- 3. All dated and itemized receipts for meals. Including the number of people dining.
- 4. Itemized receipts for purchased or rented durable medical equipment not covered by insurance.

Available reimbursement:

- 1. Mileage: Paid at \$0.45 per mile (mileage determined by MapQuest)
- 2. Lodging: Paid up to \$125.00 per night
- 3. Meals are paid as follows:
 - a. Breakfast paid up to \$10 per person
 - b. Lunch paid up to \$15 per person
 - c. Dinner paid up to \$20 per person
- 4. Durable medical equipment not covered by insurance. Limits may apply.
- 5. Other medically needed items not covered by insurance. Limits may apply.

I understand that all information is confidential and will be made available only to the Avery Foundation Board of Directors and its associated partners for the sole purpose of determining initial and ongoing eligibility for assistance.

Signature of applicant:_____ Date:_____

Signature of parent/guardian in under 18 yrs old:

Grants from the Avery Foundation are made possible by many private donors and these fine businesses!

