Please return completed application to:

LCGH Fund for Hope
Lewis County Hospital Foundation
7785 North State Street
Lowville, NY 13367

Email: fundforhope@lcgh.net
Phone: 315-376-5493
Fax: 315-376-9317

**CONFIDENTIAL APPLICATION**

## SECTION 1: PATIENT INFORMATION

Patient name: _____ Date of Birth: _____ Gender: M / F

Address:_____

City/Town: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____ Email: _____

Are you a resident of Lewis County or do you use the services of Lewis County General Hospital?
Circle one: Yes No If you circled no, you do not qualify for the Fund for Hope.

How did you learn about the Fund for Hope? Social Worker ___ Word of Mouth___ Clinic or Doctor___
Cancer Services Programs ___ Hospital/Foundation Website ___ Hospital Foundation facebook page___

## SECTION 2: CANCER TREATING PHYSICIAN INFORMATION

Physician's Name: _____

Address: _____

Office Phone: _____ - _____ - _____ Office Fax: _____ - _____ - _____

I HAVE CONTACTED THE LCGH FUND FOR HOPE FOR TRAVEL ASSISTANCE AND HEREBY AUTHORIZE MY DOCTOR TO RELEASE INFORMATION REGARDING MY (OR MY CHILD'S) ILLNESS AND TREATMENT TO THE LCGH FUND FOR HOPE. I AM SUBMITTING THIS APPLICATION FOR TRAVEL ASSISTANCE DUE TO THE FINANCIAL BURDEN INCURRED AS A RESULT OF CANCER.

Applicant's Signature: _____ Date: _____

***Must be signed by the patient***

## SECTION 3: TO BE COMPLETED BY CANCER TREATING PHYSICIAN

Patient Name: _____ Date of Dx: _____

Dx: _____ Type of Treatment: _____

Treatment Location: _____How Often:_____

Physician's Signature: _____ Date: _____

***Note: The cancer treating physician section must be completely filled out to be considered for funding.***

For office use only-Date Approved: _____