Application for Financial Assistance

Last Name:_____ First Name:_____ Birth Date:_____

Street Address:_____

City:_____ State: _____ Zip:_____

Day Phone: (_____)_____ Other Phone: (_____)_____

Email:_____

Type of cancer you are currently being treated for:

☐ Breast ☐ Ovarian ☐ Uterine ☐ Cervical ☐ Endometrial

Cancer Center you are being treated at:

☐ HCMC ☐ Maple Grove ☐ Buffalo ☐ Northland ☐ Glencoe ☐ North Memorial ☐ Methodist ☐ CentraCare
☐ Mercy ☐ Monticello ☐ Unity ☐ Ridgeview ☐ Sibley ☐ U of MN Health ☐ Fairview Maple Grove

Name of Physicians:

Oncologist:_____ Radiation Oncologist:_____

Surgeon:_____ Plastic Surgeon:_____

Current Treatment: *(check all that apply)*

☐ Chemotherapy ☐ Radiation ☐ Surgery
☐ Other:_____

Have we helped you before?

☐ Yes ☐ No Date:_____

Circumstances leading to current need:

_____
_____
_____
_____

I declare that the information on this application is true and correct, and hereby give my permission for my medical records to be obtained.

Signature:_____ Date:_____

Please submit this application by email to payitforward@ridgeviewmedical.org, or by fax to 952-442-6049, or mail to Pay It Forward Fund c/o Ridgeview Foundation, 490 S Maple Street, Suite 110, Waconia, MN 55387. Once you are approved, you will be notified. At that time, we will request that you submit your bills. For questions, call 952-777-5100.

Cancer doesn't care if you get behind on your bills. We do.