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 ☐ M Health Fairview (check specific location below)

☐ *Burnsville* ☐ *Edina* ☐ *Maplewood* ☐ *U of M*

☐ *Maple Grove* ☐ *Woodbury* ☐ *Wyoming*

Please indicate your ethnicity. This does not impact your grant eligibility.:

☐ White or European American, non-Hispanic ☐ Black or African American, non-Hispanic ☐ Multi-racial identity

☐ Native (or Indigenous) Hawaiian/Pacific Islander ☐ Asian American, non-Hispanic ☐ Hispanic/Latino American

☐ Native (or Indigenous) American/Alaska Native ☐ Other (non-American) racial identity

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, 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.