Korean American
HELPING HANDS
FOUNDATION, INC.

137-10 Franklin Ave. #L1, Flushing, NY 11355
TEL: 718-359-0005

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Today's date: _____ Date of birth: _____ (mm) / _____ (day) / _____ (yy)

First name: _____ Last name: _____ Gender: Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Email address: _____@_____

MEDICAL INFORMATION

Date of diagnosis: _____ Primary cancer: _____ Current stage _____

Type of treatment: Chemotherapy ☐ Radiation ☐ Surgery ☐ Palliative care ☐

Bone marrow/ stem cell transplant ☐

Hospital name: _____ MD name: _____ Phone number of MD: _____

FINANCIAL INFORMATION

Type of insurance: No insurance ☐ Private insurance ☐ Medicaid ☐ Medicare ☐ Charity care ☐

Number of people in your home: _____ Are you currently employed? Yes ☐ No ☐

Family income sources: Social security ☐ SSD (disability) ☐ SSI (low income) ☐ Unemployment ☐

Public assistance ☐ Short-term disability ☐ Family or friend support ☐ Other: _____

Total annual current family income (1 year): $_____

Please be aware that funds are limited and based on availability. Patients must also meet KAHHF eligibility requirements. We do not provide grants for mortgages, car insurance, medical bills or insurance copayment. If you need this type of assistance, a hospital social worker may be able to refer you to a local agency for help.

Patient Signature: _____ **Date**: _____

Relationship to patient applying for help: Self ☐ Spouse ☐ Caregiver ☐ Health care professional ☐

THANK YOU

Mail this form to Korean American Helping Hands Foundation, 137-10 Franklin Ave. #L1, Flushing, NY 11355

We will review this information and contact the person requesting financial assistance.

All information is strictly confidential and is for KAHHF use only.

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