GYNCA
GYN CANCERS ALLIANCE
Education. Support. Resources.

NON-MEDICAL FINANCIAL ASSISTANCE APPLICATION

Application for assistance will be evaluated by the organization after completion of this form & verification from your health care provider.

YOU MUST BE IN CURRENT CHEMO/RADIATION TREATMENT IN ORDER TO QUALIFY.
THIS FORM IS REQUIRED & MUST BE COMPLETED TO RECEIVE ANY FINANCIAL ASSISTANCE FROM GYNCA.

Name: _____ DOB: _____

Address: _____ County You Reside In: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Spouse/Partner: _____ Spouse/Partner Phone: _____

Name & Age of Children Living in the Home: _____

_____

GYNCA pays invoices only. NO cash or reimbursements will be provided directly to you as a member.
It is never a guarantee that GYNCA will be able to assist with all aspects of your monthly expenses & is based upon available funding.
The amounts below are estimates used only for budgeting. We do not require any proof of pay stubs, taxes, or bank statements.

MONTHLY INCOME	CURRENT	MONTHLY EXPENSES	CURRENT
Employment:		Rent/Mortgage	$_____
Patient Monthly Income	$_____	Utilities/Phone/Cable	$_____
Spouse Monthly Income	$_____	Food	$_____
Retirement:		Medical Supplies/Meds	$_____
Social Security/Disability	$_____	Health Insurance	$_____
VA/Employee Pension	$_____	Car/Home Insurance	$_____
Other Income:		Auto Payment / Gas	$_____
Alimony	$_____		
Child Support	$_____	**Other Expenses:**	
Public Assistance	$_____	_____	$_____
Workmen's Comp	$_____	_____	$_____
Unemployment	$_____	_____	$_____

To be eligible for Non-Medical Financial Benefits, you must be in current chemo/radiation treatment for a Gynecologic Cancer.
We will update your file to determine eligibility and verify your gynecologic cancer status. All information is considered confidential & will be used only for eligibility determination. You may be asked to discuss benefits of assistance. I hereby certify that I have been diagnosed with a gynecologic cancer & require financial assistance. I certify that the above information is true & correct.

Signature: _____ **Date:** _____

By signing this form, you grant GYN Cancers Alliance permission to get updates from your doctor as needed to verify treatment for Non-Medical Financial Assistance for 3 years from date signed.

Send completed form to GYN Cancers Alliance, 3039 S Fort Avenue Suite A, Springfield, MO 65807 or email to info@gynca.org.
Please do not fax this form, as the fax will come through as a black page.