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# Financial Request Form

The Ovarian Cancer Community Outreach, Inc. (OCCO) is a 501(c)(3) organization founded to assist those impacted by ovarian and other gynecological cancers as well as ovarian cancer research. OCCO, Inc. assists individuals regardless of age, gender, race, religion or sexual orientation.

To be eligible for financial assistance you must be undergoing treatment for ovarian or other gynecological cancer. The patient needs to be living or receiving treatment in Wisconsin, unless otherwise approved by the OCCO Board of Directors. Preference may be given to those residing in Brown County and surrounding counties. Applicant's income restriction is 250% or less of federal poverty levels and/or whose insurance/Medicare assistance is not sufficient for applicant to maintain financial stability.

**Please complete the request form and mail to OCCO, PO Box 1176, Green Bay, WI 54305 or email to info@occo-wis.org.**

Applicant's name_______________________________________________ Date of birth________________________

Address_______________________________________________City________________________Zip____________

Phone numbers (please day and night time) ____________________________________________________________

E-mail address ____________________________________________________________________________

Person completing form_________________________________ Relationship to applicant______________________

Household income/financial status including and disability income______________ Number in household ________

**Please have the following section completed by applicant's Oncologist/Surgeon and emailed or mailed to OCCO, Inc. by your physician:**

(Name)_______________________________________is a patient of mine and is currently receiving cancer treatment.

Doctor's signature_________________________________________________Date____________________________

Doctor's name, please print__________________________________________ Phone number__________________

Email address ______________________________________________________________________________

Location of treatment (clinic and city) __________________________________________________________________

Type and stage of cancer_____________________________________________________________________

Other information relevant to request____________________________________________________________

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**This section to be completed by patient or representative.**

**Copies of bills/receipts must accompany this request.** Unfortunately checks CANNOT be made out directly to the requestor.

Request ____________________ Amount requested________________ Check payable to____________________________
Bill name of recipient. Can't be written to the requestor.

❏ Rent ❏ Utilities ❏ Daycare/Home assistance
❏ Transportation/lodging ❏ Physician fees ❏ Diagnostic fees
❏ Hospital expenses ❏ Medications ❏ Personal assistive devices
❏ Wigs, head coverings
❏ Other: ____________________________________________________________________________________

**Total Amount Requested**____________________________________

❏ Please check here if you have received assistance from OCCO in the past.

If approved, OCCO, Inc. will send the check to you made payable to bill recipient. It is your responsibility to distribute the checks to the recipient(s). Recipient is limited up to $1,500 annually.

Please add any other information that would be relevant to consider_____________________________________________

__________________________________________________________________________________________________

Would you be willing to share your story/experience with others? ________________________________________________

Preferred method of being contacted? ______________________________________________________________________

May a representative from OCCO, Inc. contact you? ____________________________________________________________

I certify that the information provided in this application is true and accurate. I understand that the withholding of any information sought by this application, or the giving of false information on this application may result in my disqualification from consideration for the Ovarian Cancer Community Outreach's financial assistance.

Signature_____________________________________________________ Date_________________________

Please indicate if: ❏ patient or ❏ representative

PLEASE REMEMBER TO ATTACH YOUR BILLS FOR PAYMENT

The Ovarian Cancer Community Outreach, Inc. bears no responsibility on patient's treatment options or decisions.