The Eric R. Beverly Family Foundation

Alger County Chemotherapy and Mammography Program Fund
1475 Buford Drive, Suite 403-127, Lawrenceville, GA 30043
Phone: 770.614.1779 • Fax: 678.302.7116 • Web: beverlyfamilyfoundation.org

Patient Information
(Please Print)

Last Name: _____ First Name: _____ Date: _____
Address: _____ City/State/Zip: _____
County: _____ ☐ Male ☐ Female
Phone: Home: ( ) _____ Date of Birth: _____
Work: ( ) _____ Age: _____ Ethnicity: _____
Cell: ( ) _____ (Please specify)
E-Mail: _____ If patient is a minor, name of parent or guardian
_____

Currently Employed: ☐ Yes ☐ No Self Employed: ☐ Yes ☐ No Citizen of the United States ☐ Yes ☐ No
*If no, please have immigration documents.
Place of Employment: _____
Address: _____
Telephone Number: ( ) _____

For TERBFF Use Only: CHAMP Fund Grant Type _____ #_____

Financial Information

MONTHLY EXPENSES	FAMILY ASSETS	INCOME SOURCE
Rent/Mortgage: _____	Checking: _____	Salary: _____
Utilities/Phone: _____	Saving/CD: _____	Public Assistance: _____
Child Care: _____	Money Market: _____	Child Support: _____
Transportation: _____	Stocks: _____	Family/Friends provide support: _____
Medical Bills/Other Debt: _____	Bonds: _____	SSD (Disability): _____
Food: _____	Other: _____	Short Term Disability: _____
Other: _____		In-Kind (room and board): _____
		Pension: _____
		Social Security (retirement): _____
		Sick Leave Pay: _____
		SSI: _____
		Unemployment: _____
		Alimony: _____
		Other: _____
TOTAL: 0	**TOTAL:** 0	**TOTAL:** 0

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Please indicate the grant category for which you are applying:

_____ Alger County CHAMP Fund Grant

Please indicate how you plan to use the funds:

☐ Transportation ☐ Child Care ☐ Home Care ☐ Pain Medication ☐Chemotherapy ☐ Radiation ☐ Copay ☐ Other _____

_____ Energy Relief Fund

Please indicate how you plan to use the funds:

☐ Rent/Mortgage ☐ Water/Sewer ☐ Gas/Propane ☐ Electricity ☐ Phone/Cable ☐ Other _____

_____ Grant for Non-Breast Cancers Type of Cancer: _____

Health Insurance Information

Do you have health insurance? ☐ Yes ☐ No Name of Health Insurance Company: _____

If yes, please indicate type of insurance: (check all that apply)

☐ Medicaid ☐ Private Insurance ☐Medicaid Pending ☐ Public Health Insurance ☐Medicare Only ☐ Emergency Medicaid

☐ VA Program ☐ Medicare Plus Medicaid ☐ Charity Care ☐ Medicare Plus other supplemental coverage

Are prescription drugs covered? ☐ Yes ☐ No

Annual Deductible Amount: $ _____ Have you met your deductible? ☐ Yes ☐ No

FAMILY COMPOSITION (list yourself and all others in your household)

Name	Relationship to Head	Age	Sex (M/F)	Birthdate	Legal Dependent (Y/N)	Handicapped Disabled (Y/N)	Student (Y/N)	Social Security # Alien Registration #

For statistical purposes only:

Head of Household: Please check one in each category

Marital Status

Married ☐
Single ☐
Widowed ☐
Divorced ☐
Separated ☐
NA ☐

Race

White ☐
Black ☐
American Indian or Native Alaskan ☐
Asian or Pacific Islander ☐
Hispanic ☐

Employment Type

Professional, Technical ☐
Manager, Supervisor ☐
Clerical, Sales ☐
Skilled, Semi-skilled, Foreman ☐
Unskilled, Service ☐
Retired ☐
Student ☐
Unemployment ☐

I solemnly swear that the information contained in this application is true to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Full Name: _____

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Address: _____ City/State/Zip: _____
County: _____ ☐ Male ☐ Female
Phone: Home: ( ) _____ Date of Birth: _____
Work: ( ) _____ Age: _____ Ethnicity: _____
Cell: ( ) _____ (Please specify)
E-Mail: _____ If patient is a minor, name of parent or guardian
_____

To Be Completed by your Doctor, Nurse, or Social Worker Only: Medical Information

Date of Diagnosis: _____ Primary Cancer: _____

Stage of Cancer: _____ ☐ New Diagnosis ☐ Recurrence In Active Treatment? ☐ Yes ☐ No

If yes, please indicate type of treatment (Check all that apply):

☐ Chemotherapy ☐ Radiation ☐ Clinical Trail ☐ Surgery ☐ Hormonal ☐Palliative Care ☐ Lumpectomy

☐ Bone Marrow/Stem Cell Transplant ☐ Complementary/Alternative ☐ Mastectomy ☐ Double Mastectomy

If no, is Post Treatment follow up needed? ☐ Yes ☐ No

If yes, please indicate type of follow up: ☐ Yearly ☐ Every Six Months ☐ Other _____

MD Name: _____ Hospital/Clinic: _____

Address: _____

City/State/Zip: _____ Phone: ( ) _____ Fax: ( ) _____

Signature of person completing this section: _____

Print Name/Title: _____

Phone (if different than above): ( ) _____ Email Address: _____

Relationship to person applying for help: ☐ Doctor ☐ Nurse ☐Social Worker

Thank you. A TERBFF worker or case manager will review this information and contact the person requesting help. Funds are limited and based on availability. **Please fax this form to (678) 302-7116, Scan & Email to info@beverlyfamilyfoundation.org or mail immediately to:** 1475 Buford Drive, Suite 403-127, Lawrenceville, GA 30043. All information is strictly confidential and is for TERBFF use only.