Luna Cares Fund Assistance Application

Patient Contact Information

Name:

Address:

Phone:

Email:

Age:

Gender:

Name of Hospital(s) Where You Receive Treatment:

Are you willing to be contacted by a Luna Board Member or Volunteer to discuss how we might best assist you? Y/N (drop down)

Patient Background and Assistance Request:

***NOTE: All information you provide in this application is strictly confidential and will only be used by Luna Cares Board Members to determine the best means for patient assistance.**

Please share any details you are comfortable sharing regarding your diagnoses, duration of illness and course of treatment:

Please describe the ways that Luna Cares could best assistance you (financially or otherwise) to meet your medical or daily needs:

Please describe your current financial and employment situation (Are you employed? Do you have health insurance? Do you face outstanding medical bills?):

Treating Physician Information:

Name of Physician:

Physician's Phone Number:

Physician's Office Address or Hospital Address: