Patient Assistance Program Application

The Outlaw Foundation is a 501(3) c Non-Profit organization which helps patients who are currently undergoing chemo or radiation therapy or who are within one year of completing therapy.

Patient Name_____ DOB_____
Patient Address_____
Patient Home Phone _____Cell_____
Married_____ Single_____ Widowed_____ Number of Dependents_____
Male __ Female__ Insurance_____
Cancer Dignosis_____

Gross Monthly Income **Proof of Income Received Yes___No___**

Income	Monthly	Spouse	Yearly	Notes:
Salary	$_____	$_____	$_____	
Pension	$_____	$_____	$_____	
Social Security	$_____	$_____	$_____	
SSI Supp Income	$_____	$_____	$_____	
Disability	$_____	$_____	$_____	
Unempolyment	$_____	$_____	$_____	
Alimony/Child Sup	$_____	$_____	$_____	

Total Yearly Household Income $_____

References:

1. _____Explain:_____

2. _____Explain:_____

3. _____Explain:_____

Note: If more room is needed please use back of application for References:

Patient has been approved for a total of $100.00 for one month. Effective date_____

Approved By_____ Date_____

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility for assistance through The Outlaw Foundation. I agree to inform The Outlaw Foundation of any change of condition or circumstances that might impact my eligibility. Any untruthful of fraudulent information provided or my refusal to cooperate with the eligibility process may be grounds for denial of assistance. I also understand that the above information may be provided to other third party patient assistance programs on my behalf.

Patient or Family Signature: _____ Date: _____

Applications can email or mailed to:

The Outlaw Foundation
PO BOX 592
Faison, NC 28341

Or:
Boutlaw32@gmail.com