Betty Kearns Cancer Fund

Patient Financial Assistance Application

Application to be completed by medical social worker, oncology nurse navigator or oncology nurse manager.

Patient Name:
____

Patient Address:
____

____

Payable to:
____

Please describe the reason for request:

Is this patient currently being treated for cancer at (insert hospital name________________)?

Is the patient a St. Clair County or Sanilac County resident?

Has financial need been demonstrated and documented? _______________

Amount of request $_____________

(If more than $1,000, Fund Committee must provide additional approval)

If approved, check will be made out to the creditor and sent to the patient directly.

Please send this request to the Betty Kearns Cancer Fund Committee at bettykearnscancerfund@gmail.com