

Client Services Application



Applicant Information

Name:	
Street Address:	
City, ZIP Code:	
Home Phone:	
Work Phone:	
Cell Phone:	
E-Mail Address:	
Date of Birth:	
Gender (Circle One)	M or F

Programs

How can we help?

Meal Assistance

Transportation Assistance

Other Non-Medical Assistance, Please Specify:

Are you receiving any other assistance? If so explain: _____

Medical Status

Diagnosis:

Date of Diagnosis:

Currently in Treatment (Circle one): Y or N

Type of Treatment:

Projected Length of Treatment:

Referral Information

How did you hear of us?

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Household Information

Please tell us a little bit about your family

First name	Date of Birth	Sex

Additional Information you would like us to know about you and your family:

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Confidentiality Statement: The use of this application is used solely for determining eligibility for assistance from Helping Hands & Hearts Foundation, Inc. (HH&HF) This information will be kept in confidence and used only within HH&HF.

Any person who makes or causes to be made knowingly false or fraudulent material statements or material misrepresentations for the purpose of obtaining aid from HH&HF is subject to immediate disqualification of assistance.

Submission of an application does not guarantee funding or approval of assistance.

Signature

I affirm that I am in need of assistance from Helping Hands & Hearts Foundation, Inc. related to my cancer diagnosis. I currently reside in Santa Clarita Valley, Antelope Valley or surrounding area. I have read and understand the Confidentiality Statement above.

Name (printed)	
Signature	
Date	