H.U.G.S. CHARITIES, INC. &
CANCER ALLIANCE OF MARION COUNTY
P.O. Box 34, Ocala, Fl. 34478
RBOI ROBERT BOISSONEAULT ONCOLOGY INSTITUTE
Community Partner

HUGs Patient Assistance Program

Submit form to: Hugspatientassistance@gmail.com

Applicant Name: _____ Date of Birth: _____

Address (Street, City, County, State):_____

E-Mail Address: _____ Phone #:_____

# of adults in household: _____ (Household refers to all persons currently living in the home).

# of persons under 18 (dependents) in household: _____

Are you on unpaid leave: YES/NO Has your income decreased since diagnosis? YES/NO

Do you receive any of the following and if so, how much per month: SSI/Disability: $_____

Food Stamps: $_____ Alimony/Child Support: $_____Unemployment: $_____

Other income: $_____ FROM WHAT: _____

Total monthly income (all household members) including government assistance: $_____

Total monthly expenses: $_____

Is this your first request through H.U.G.S. Charities? YES/NO.

If no, how long ago was your last request: _____?

To be completed by your doctor's office:

Cancer Center Name/Address:_____

Office Contact: _____ Phone: _____

Diagnosis: _____ Date of Diagnosis: _____

Is patient currently undergoing treatment? _____

Radiation ___ Surgery ___ Chemotherapy ___ Routine Infusions ___

Follow up Care (if so how often? _____)

*Signature: _____ Title: _____

*Must be an RN, Social Worker, Navigator, or Physician, or Physician Assistant/Nurse Practioner

To be completed by HUGs: REQUEST #:_____ Date Received_____

Follow up by: _____ PREVIOUS REQUEST #'S:_____ Date Closed Out/Completed _____

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Please state the reason for this request for help (ex: loss of income, increased expenses, hardship for travel, family member lost job, homeless, etc.) and what assistance you need, (i.e. gasoline, utility bills, rent, etc.):

_____

_____

_____

_____

_____

Approved payments are made directly to the Landlord, or Utility Company, etc. Please list agency name and address below. ****Must attach a copy of the Bill/Lease Agreement!***

Payment to: Company Name and Address Type of help (Rent, gas, etc.) Amount

1. Company Name: _____
   Address: _____ _____ $_____
2. Company Name: _____
   Address: _____ _____ $_____
3. Company Name: _____
   Address: _____ _____ $_____

Gas Cards $ _____ Grocery Cards $ _____

Total amount requested: $_____

I/We understand that our participation in the H.U.G.S CHARITIES, INC. (H.U.G.S) AND THE CANCER ALLIANCE OF MARION COUNTY (CAMC) is voluntary and these benefits are a humanitarian endeavor to provide financial support and assistance to patients and patient's families who are bailing cancer who are experiencing difficulties. I/We hereby release, discharge, and agree to hold harmless H.U.G.S and CAMC, its officers, directors, agents, sponsors, medical advisors, volunteers and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or accidental to our participation in the programs or benefits provided by H.U.G.S. and The Cancer Alliance of Marion County.

I/We release H.U.G.S. Charities Allocation Commiiee to verify with my cancer treatment provider that I am a patient and receiving treatment. I hereby certify that all above information submiied and statements I have made are true and agree that any false information or misrepresentation of facts may result in the cancellation or immediate dismissal of my request. I also declare neither the patient nor members of the household use illegal narcotics and are not actively involved in criminal activity. **ATTENTION – BY SIGNING BELOW, YOU AGREE TO HAVE YOUR APPLICATION E-MAILED TO HUGS CHARITIES. IF ANY COMPUTER SYSTEM IS COMPROMISED, YOU WILL NOT HOLD ANY PERSONS INVOLVED RESPONSIBLE. IF YOU DO NOT WISH TO HAVE YOUR INFORMATION E- MAILED, PLEASE MAIL TO PO BOX 34, OCALA, FL 34478. You also agree to the Assistance from HUGs Policy available at HUGscharities.org.**

To be completed by HUGs: REQUEST #:_____ Date Received_____

Follow up by: _____ PREVIOUS REQUEST #'S:_____ Date Closed Out/Completed _____

Applicant Signature: _____ Date: _____