PERSONAL INFORMATION

Name			
Date of Birth		**Social Security #**	
Street Address			
City, State, Zip		**County****	

THE LYN FUND PROVIDES ASSISTANCE TO RESIDENTS OF PINELLAS OR PASCO COUNTY, FLORIDA ONLY. IF YOU RESIDE IN ANY OTHER COUNTY OR STATE, PLEASE STOP HERE.

Email			
Home Phone		**Cell Phone**	

Marital Status *(check one)*	❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partnered ❒ Separated	**# Wage Earners in Household**	
		Total # of People Living in Household	
		Number & Age of Dependents in Household	

Employment Status BEFORE your cancer diagnosis *(Please check all that apply)*

❒ Full Time	❒ Part Time	❒ Retired	❒ Self Employed
❒ Unemployed	❒ FMLA	❒ Disability	❒ Sick Leave

Employer Information

Name			
Primary Contact			
Phone		**Email**	

Current Employment Status *(Please check all that apply)*

❒ Full Time	❒ Part Time	❒ Retired	❒ Self Employed
❒ Unemployed	❒ FMLA	❒ Disability	❒ Sick Leave

Date Last Worked		*Provide month/date/year*
Disability Insurance	❒ Yes ❒ No	*NOT Social Security Insurance Disability or SSID*
If yes, fill in your waiting period		
How much is received	$	❒ Weekly ❒ Monthly
How many months		
If on disability/sick leave, are you receiving any compensation?	❒ Yes ❒ No	

HEALTH INSURANCE *(Please check one)*

❒ None	❒ Medicare	❒ Medicaid	❒ Private
❒ Supplied by Employer (self or spouse)	❒ Other: _____		

Applicant Name	

MY STORY

Tell us about you, your story and how a LYN Fund award would make a difference to you and your family during this time. Please include any information about your current or expected financial situation that you would like us to know, or that you think would help us make a decision - such as a financial hardship, excessive medical expenses, seasonal or temporary income, personal loss, or any other special circumstance that may be impacting you.

Write *Your Story* below, or feel free to attach a separate page to the application along with anything else that you may want to share with our Board as they consider your application for approval.

Applicant Name	

MEDICAL INFORMATION

PLEASE HAVE THIS PAGE FILLED OUT BY YOUR ONCOLOGIST, PATIENT ADVOCATE OR NURSE

Current Diagnosis:

Date Diagnosed		
Type of Cancer		
Stage/Grade		
Chemotherapy	Start Date	End Date
Radiation	Start Date	End Date

Other Therapy or Treatment Details

Form Completed by: _____ _____

Signature Date

_____

Printed Name *(please print)*

_____

Phone

_____

Hospital or Oncology office

Applicant Name	

ADDITIONAL MEDICAL CONTACTS

Please provide the name, e-mail address and phone number for the following providers with whom we may discuss your application. If we can't reach you or need further information (also complete the HIPPA release form, page 7).

Surgeon

Name			
Primary Contact			
Phone		**Email**	

Oncologist

Name			
Primary Contact			
Phone		**Email**	

Oncology Nurse

Name			
Primary Contact			
Phone		**Email**	

Other Contact(s):

_____

_____

_____

Please read these items carefully and check the boxes that are true:

- ☐ I understand The L.Y.N. Fund does not pay for medical expenses of any kind.
- ☐ I am currently a patient either recovering from a cancer-related surgery, and/or I am currently undergoing chemotherapy or radiation.
- ☐ I give my full authorization and permission to The L.Y.N. Fund to obtain the necessary medical information to process my application.
- ☐ I understand that The L.Y.N. Fund may ask personal questions about my treatment and financial status. I agree to provide accurate answers.

Applicant's Signature: _____ Date: _____

****You must also complete all pages of this application to be considered, including the Financial Disclosure Form, the HIPAA Authorization Form, and provide all documents requested.* ***Please include a copy of your drivers license with this application.*****

Applicant Name	

FINANCIAL DISCLOSURE FORM

Monthly Income	**Self**	**Partner**	**Total (Partner & Self)**
Salaries			
Social Security Disability and/or State Disability			
Workers Compensation			
Pension and/or Annuity Payments			
Alimony			
Child Support			
Interest/Dividends from assets / Gross rent from rentals properties			
Disability Policy benefits or sick pay from Employer			
Total Monthly Income:			

Expenses	**Monthly Amount**	**Expense**	**Monthly Amount**
Mortgage / Rent		Home Insurance	
Car Payment		Car Insurance	
Health Insurance		Groceries	
Electric		Cell Phone	
Water/Sewer		Home Phone	
Internet/Cable		Child Support Payments	
Gas		Monthly Medical Expenses *Use separate sheet but include total here*	
Trash		Other: _____	
Other: _____		Other: _____	
		Total Monthly Expenses:	

Total Monthly Net Income (Income less Expenses)

Applicant Name	

REQUEST FOR FUNDING INFORMATION

Please rank which expenses you'd like The LYN Fund to consider paying that would provide the most financial relief. **Please rank your priorities using numbers – starting with 1 as the most helpful**. Please note that The LYN Fund does not pay any credit card accounts or medical related bills.

Priority/Rank	Bill Type	Paid To
	Mortgage / Rent	
	Car Payment	
	Electric	
	Gas	
	Water/Sewer	
	Trash Service	
	Internet/Cable	
	Home Phone	
	Cell phone	
	Car Insurance	
	Other:	
	Other:	
	Other:	

Please list other organizations to which you have applied for assistance:

_____

_____

_____

_____

_____

Applicant Name	

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164, "HIPPA").

1. AUTHORIZATION
   I_____(*PRINT NAME*) authorize _____
   _____ (*YOUR TREATING PHYSICIAN)* to disclose the protected health information described below to The L.Y.N. Fund, Inc.

2. EFFECTIVE PERIOD
   This authorization for release of information covers the period of healthcare from_____ (*DATE*) to and through_____ (*DATE*).

3. EXTENT OF AUTHORIZATION
   I authorize the release of my health record only as it pertains to my cancer diagnosis and treatment.

4. This medical information may be used by The L.Y.N. Fund, Inc. for the purpose of evaluating my eligibility for financial aid according to their guidelines or for other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (*DATE*), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7. I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT (OR PERSONAL REPRESENTATIVE):

_____ _____
Signature Date

_____
Print Name

APPLICANT RELEASE FORM

1. I, _____ hereby grant The L.Y.N. Fund, Inc., its agents, community and business partners, subsidiaries and affiliates, and their respective licensees, successors and assigns the right to use, disclose, maintain, copy, publish, transmit, copyright and permit others to use my image, likeness, name, and personal information, including my story about The L.Y.N. Fund, Inc. and the grant/contribution that I received for commercial or non-commercial purposes, including advertising, public relations, promotion of The L.Y.N. Fund, Inc., its products and services and its partners or affiliates. This will extend to any medium or format whatsoever, including without limitation, in and on magazines, brochures, and other print publications, press releases, electronic media, and he internet (including the website and social media sites of The L.Y.N. Fund, Inc.

2. I further agree and do hereby release and hold harmless The L.Y.N. Fund, Inc. from any and all claims, actions, suits, liabilities or damages arising from use of the Content and weather resulting from the negligence of The L.Y.N. Fund, Inc. or any other person, I waive any right I may have to make or bring any claim against The L.Y.N. Fund, Inc. relating to its use of the Content. I understand and agree that I will not be compensated in any way for providing the Content to The L.Y.N. Fund, Inc. or authorizing its use in the manner detailed herein.

3. Distribution of funds to any application is at the sole discretion of The L.Y.N. Fund, Inc., and its Board of Directors.

I HAVE CAREFULLY READ, CLEARLY UNDERSTAND AND VOLUNTARILY ACKNOWLEDGE THE INFORMATION SET FORTH IN THIS RELEASE FORM. I UNDERSTAND THAT THIS FORM PROVIDES THE L.Y.N. FUND, INC. WITH MY ABSOLUTE AND UNCONDITIONAL CONSENT, WAIVER AND RELEASE OF LIABILITY, ALLOWING THE L.Y.N. FUND, INC. TO PUBLICIZE PRIVATE INFORMATION ABOUT ME. BY SIGNING THIS RELEASE FORM, I UNDERSTAND IT HAS NO BEARING ON ANY DECISIONS MADE BY THE QUALIFICATIONS COMMITTEE REGARDING FINANCIAL ASSISTANCE.

Date: _____

Applicant Name: _____

Signature: _____

Address: _____

Witness Name: _____

Signature: _____

Address: _____

Please send this COMPLETED APPLICATION (all pages), plus (1) a copy of your driver's license, (2) any supplemental information requested, (3) or any additional info that the applicant would like The LYN Fund to consider as part of their request by email to: Info@theLYNfund.org.

The LYN Fund will review all applications and be in touch if additional information is required to present your application to its Advisory Board for approval. An Application for Financial Assistance will not be considered unless it is complete. Applications are presented and reviewed monthly, and you will be notified of your final application status usually within thirty (30) days of receipt.