THE CROCUS FOUNDATION

Application for Financial Assistance

First Name: ______________________ **Last Name:** ____________________ **Date of Birth** ___________

Address: ____________________________________ **City:** ___________________ **State:** _______ **Zip:** ________

Primary Phone: _____________ **email address:** ____

Emergency Contact Name: _________________________________ **Emergency Contact Phone:** _____________

Assistance is available to residents in the Tri-State are in the following counties, please select the county you reside in:

Iowa: ☐Dubuque, ☐Clayton, ☐Delaware, ☐Jackson,☐ Jones

Illinois: ☐Jo Daviess

Wisconsin: ☐Grant

Name of Referring Oncology or Primary Care Physician: ____

Phone Number: _____________________________ **email address:** ____

A brief summary of diagnosis and current stage of treatment/remission (Please attach any relative treatment information to help with assessment). ____

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Personal Statement outlining purpose of the request: ____

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1000 Jackson Street, Dubuque Iowa 52003 P: 563-239-9493 email: thecrocusfoundation@gmail.com

Because the assistance provided by The Crocus Foundation is determined based on need, we are asking for general information regarding personal income:

Average Annual Household Income:

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Other income details that illustrate need:

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Available Funding Opportunities*:

☐ One month of initial prescribed exercise training program: $300

☐ Fitness Center Monthly Membership fees of $25/month up to $300/year. *(Must have completed initial month of prescribed exercise training).*

☐ Annual prescribed exercise program expenses*. Requests up to $500/quarter and will be added to the patient's survivorship account, to be allocated to services as they are completed.

$3,700/individual/year maximum total scholarship
****Quarterly requests should be based on number of projected sessions per week/per price of session.***

I understand that all information is confidential and will be made available only to The Crocus Foundation Board of Directors and its associated partners for the sole purpose of determining of initial and ongoing eligibility for assistance.

Signature of Applicant

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Signature of Parent or Guardian

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Date:

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For office use only:

Board of Director Reviewer: ____**Date:**
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____

Board of Director Reviewer: ____**Date:**
____

Approval Amount: __________________

Award Date: ________________________

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