

Financial Request Form

The Ovarian Cancer Community Outreach, Inc. (OCCO) is a 501(c)(3) organization founded to assist those impacted by ovarian and other gynecological cancers as well as ovarian cancer research. OCCO, Inc. assists individuals regardless of age, gender, race, religion or sexual orientation.

To be eligible for financial assistance you must be undergoing treatment for ovarian or other gynecological cancer. The patient needs to be living or receiving treatment in Wisconsin, unless otherwise approved by the OCCO Board of Directors. Preference may be given to those residing in Brown County and surrounding counties. Applicant's income restriction is 250% or less of federal poverty levels and/or whose insurance/Medicare assistance is not sufficient for applicant to maintain financial stability.

Please complete the request form and mail to OCCO, PO Box 1176, Green Bay, WI 54305 or email to occo-wis.org.

Applicant's name _____ Date of birth _____

Address _____ City _____ Zip _____

Phone numbers (please day and night time) _____

E-mail address _____

Person completing form _____ Relationship to applicant _____

Household income/financial status including and disability income _____ Number in household _____

Please have the following section completed by applicant's Oncologist/Surgeon and emailed or mailed to OCCO, Inc. by your physician:

(Name) _____ is a patient of mine and is currently receiving cancer treatment.

Doctor's signature _____ Date _____

Doctor's name, please print _____ Phone number _____

Email address _____

Location of treatment (clinic and city) _____

Type and stage of cancer _____

Other information relevant to request _____

This section to be completed by patient or representative.

Copies of bills/receipts must accompany this request. Unfortunately checks CANNOT be made out directly to the requestor.

Request _____ Amount requested _____ Check payable to _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Rent | <input type="checkbox"/> Utilities | <input type="checkbox"/> Daycare/Home assistance | Bill name of recipient.
Can't be written to the requestor. |
| <input type="checkbox"/> Transportation/lodging | <input type="checkbox"/> Physician fees | <input type="checkbox"/> Diagnostic fees | |
| <input type="checkbox"/> Hospital expenses | <input type="checkbox"/> Medications | <input type="checkbox"/> Personal assistive devices | |
| <input type="checkbox"/> Wigs, head coverings | | | |
| <input type="checkbox"/> Other: _____ | | | |

Total Amount Requested _____

Please check here if you have received assistance from OCCO in the past.

If approved, OCCO, Inc. will send the check to you made payable to bill recipient. It is your responsibility to distribute the checks to the recipient(s). Recipient is limited up to \$1,500 annually.

Please add any other information that would be relevant to consider _____

Would you be willing to share your story/experience with others? _____

Preferred method of being contacted? _____

May a representative from OCCO, Inc. contact you? _____

I certify that the information provided in this application is true and accurate. I understand that the withholding of any information sought by this application, or the giving of false information on this application may result in my disqualification from consideration for the Ovarian Cancer Community Outreach's financial assistance.

Signature _____ Date _____

Please indicate if: patient or representative



PLEASE REMEMBER TO ATTACH YOUR BILLS FOR PAYMENT

The Ovarian Cancer Community Outreach, Inc. bears no responsibility on patient's treatment options or decisions.