**The LivON Foundation's mission is to educate and promote awareness for early detection of Colon Cancer for those under fifty years of age.**
**In addition, we work to give financial support to individuals 50 and under undergoing treatment for Colon Cancer in Hampton Roads, Virginia.**

**APPLICANT'S INFORMATION** (please print clearly)

First name: ____________________________ Last name: ______________________________

Address: ________________________________________________________________________________________________
Street City State Zip

Phone: (____ _) _______-___________ Email: _____________________________________

Date of birth: _______/______/_________ Age at date of application ____ Male____ Female_____

**MEDICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY)

Date of Diagnosis _______/________/________ Primary Cancer____________ Current Stage_______

Age at Diagnosis ____ New Diagnosis ___ Recurrence___ Is patient in active treatment? Yes ___No___

If not in active treatment, indicate frequency of follow-up: ______x per year
**Please indicate type of treatment(s) received in past twelve months (circle all that apply)**

___ Chemotherapy ___ Radiation ___ Surgery

**HEALTH CARE PROFESSIONAL INFORMATION** (please print)

Name: _____________________________ Title ____________ Hospital/Clinic___________________________

Address: _______________________________________________________________________________________
Street City State Zip
Phone: (_________) ___________-___________________ Fax (__________) __________-_______________

**NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE** (please print)

Name: __________________________________________ Title________________________________________

Phone: (_________) __________-___________________ Email: _________________________@_____________

Relationship to person applying for help: ___ Doctor ___ Nurse ___ Social Worker ___ ACS navigator

**Signature of MEDICAL Professional:** ___________________________________________ _____________

**Applicants Name:**_____________________________________________ **DOB:**____/_____/____

Mail to: LivON Foundation P.O. Box 1275 ~Virginia Beach, VA 23451 OR LivONFoundation@gmail.com
www.livonfoundation.org ~ LivON is a 501(c)(3) non-profit corporation.

**This page to be completed by the patient/person requesting financial assistance**

## HEALTH INSURANCE INFORMATION

Does the patient have health insurance? ____ Yes ____No

If yes, please indicate type or insurance (check all that apply)

____ Private insurance ____ Medicaid ____ Medicare ____ Charity Care ____VA program

Are prescription drugs covered? ____ Yes____ No Are Doctor visits covered? ____Yes ____ No
What is average monthly copay for prescription drugs?______________
What is average monthly copay for doctor visits?________________

## HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed?____ Yes____ No Number of people in household: ____

**Family Income Sources :** (check all that apply)
____ Social Security ____ Salary ____ Pension ____ Unemployment
____ Public Assistance ____ Short-term disability ____ Family/friends

Total Annual Family Income**: $_____________________
**Application will not be processed if this information is not provided**

**Please be aware that funds are limited, and based on availability as well as on meeting LivON's eligibility requirements.**

**FINANCIAL ASSISTANCE NEEDS:** (Check all that apply)
_____ Transportation _____ Childcare ______ Pain Medications ______ Co-pays ______ Surgery

**Signature:** ________________________________________ **Date:** ______________________

**I attest by way of my signature that any financial assistance grants which may be awarded will be utilized for the expenses indicated above***

**The LivON Foundation is a non-profit foundation in the Commonwealth of Virginia. LivON will not utilize your information for any purpose other than to determine financial assistance as a result of treatment for Colon Cancer for those under 50 years of age. I, ____________________________________, give permission for the LivON Foundation to review my personal medical and financial information given above in an effort to provide me with financial support.**

In a few words, please describe your need for financial support: _____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**Signature of Applicant:**______________________________________. **Date:**________/_________/_________

**Printed name of Applicant:**________________________________________________.