

Foundation for Integrative Oncology ♥ P.O. Box 5031 ♥ Larkspur, CA 94977-5031
Voice Mail: (415) 721-9818

Scholarship Application Form

The Foundation for Integrative Oncology is a physician and practitioner-based grassroots effort to broaden community awareness and patient access to integrative oncology. Its goal is to enable people with cancer and their loved ones to have access to and learn about a variety of complementary therapeutic options during their state-of-the-art cancer care.

Limited scholarship funds are available. In order to receive full consideration, please complete ALL parts of this form. **Applications that are not filled out completely will not be considered.**

Initial Application Re-Application (# _____)

Please note that re-applications may only be available with a 50% patient co-pay (patients will pay 50% of the cost for 8 sessions). Thank you for your understanding.

PATIENT INFORMATION:

Name: _____ Gender: M F

COMPLETE Address: _____

Phone: (H) _____ Phone: (Cell or Work) _____

Email address: _____

Age _____ Date of birth _____ Medical Insurance: _____

Does your medical insurance provide coverage for complementary therapies? _____

MEDICAL INFORMATION:

Oncologist: _____ Diagnosis: _____

Are you actively receiving treatment? _____ If so, what type of treatment? _____

Who referred you to the Foundation for a scholarship? _____

FINANCIAL INFORMATION:

Employment Status: Working _____ Unemployed _____ Retired _____

Have you applied for Disability? _____

of adults in household: _____ # of dependents in household: _____

If more than one adult, please specify Spouse Life Partner Other: _____

Do other adults in the household contribute to the household's annual income? Yes No

Please elaborate on the following financial information for both yourself and anyone else contributing to monthly household expenses (if applicable). **Incomplete forms will not be processed.**

SELF:

Employer: _____

Annual Income (as on IRS tax form 1040): _____

Monthly gross income: _____

Monthly household Expenses: _____

SPOUSE/LIFE PARTNER/OTHER:

Please describe why you feel you need financial assistance. Your description must specifically demonstrate financial need. *If this is a re-application, please also list modalities used and describe how they benefited you.*

Share care program – *In order to maximize use of this fund by eligible patients, we request that participants pay a portion of the cost for each session. Please check the amount you are able to contribute per session: \$15 _____ \$30 _____ \$45 _____*

Please specify which modality or modalities you would like to utilize (please limit your choices to one or two modalities):

Counseling: _____ Massage: _____ Nutrition: _____ Guided Imagery: _____ Jin Shin Jyutsu: _____

Acupuncture: _____ Gentle Bodywork for Wellness: _____

Art 4 Healing: _____ *(Note: one-time material fee only)*

All information is strictly confidential and will be used only for the purpose of awarding this scholarship.

I hereby declare that the above information is true.

Signature: _____ Date: _____

Please return to the Foundation for Integrative Oncology (address on first page)