P. O. Box 165
Stockbridge, GA 30281
harborofhopesurvivors@gmail.com
www.harborofhopeinc.com

Assistance Application

____New Application ____ Application Renewal

Applicant Name: _____ Phone: _____

Applicant address: _____City_____State____ Zip Code _____County: _____

Applicant personal email: _____

Attending Physician Name: *(please print)* _____

Assistance Requested for: *(list bills and provide copies)* **List ONLY current balance**

1)_____ Amount $ _____

2)_____ Amount $ _____

3)_____ Amount $ _____

TOTAL $ _____

Example: Ga. Power Amount $ 118.35

Applicant Signature: _____Date:_____

Attending Physician USE ONLY

I confirm that the above named applicant: *(check appropriate box)*

_____ Cancer diagnosed Date _____ ____Metastatic____Recurrance

_____ Currently receiving **ACTIVE** treatment for cancer ____Chemotherapy ____Radiation ____Surgery

Physician Signature: _____NPI#_____Date:_____

Harbor of Hope, Inc. USE ONLY

Date of Application Received: _____

Verification of Information: _____

Approved: _____Date Approved: _____

Requested Amount: _____Board Approved Amount: _____ Check #_____ Total: $ _____

Harbor of Hope, Inc Application Process:

- Membership in Harbor of Hope, Inc. is not required for consideration.
- Application MUST be signed by an attending physician to be considered by Harbor of Hope, Inc.
- Include supporting documents: Current bills/receipts with submitted application. Only completed applications will be considered.
- Please allow 10-15 business days for application decisions.
- Financial Assistance is subject to Harbor of Hope, Inc. funds available.
- Upon approval checks will be sent to the applicant, payable to the service provider. Allow 3-4 weeks for receipt of funds.
- Applicants may apply no more than two times within a 12 month period.
- Assistance can be up to $500/year per the board's discretion

Revised January 2024