



# Mack D. Foundation, Inc.

PO Box 56 ~ Falcon, NC 28342  
Phone: (910)980-1501 Fax: (910)892-1418  
Email: [mackdfoundation@gmail.com](mailto:mackdfoundation@gmail.com)  
Website: [www.mackdfoundation.org](http://www.mackdfoundation.org)

## Patient Assistance Application

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Application Date: \_\_\_\_\_ Applicant Date of Birth \_\_\_\_\_ Last 4 of Social \_\_\_\_\_

**Please check what is of need:**

Household - Grocery	<input type="checkbox"/> Need	<input type="checkbox"/> Urgent
---------------------	-------------------------------	---------------------------------

Travel - Gas	<input type="checkbox"/> Need	<input type="checkbox"/> Urgent
--------------	-------------------------------	---------------------------------

**Please fill out below for applicant or legal guardian if applicant is a minor.**

Are you currently working while undergoing treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If working, have you had to reduce hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If not currently working, did you have to take temporary leave or quit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Have you ever missed treatment due to transportation difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Please tell us anything else you would like us to know.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient or Legal Guardian if a minor: \_\_\_\_\_

*"The spirit of God has made me, the breath of the almighty gives me life" ~ Job 33:4*



# Mack D. Foundation, Inc.

PO Box 56 ~ Falcon, NC 28342  
Phone: (910)980-1501 Fax: (910)892-1418  
Email: [mackdfoundation@gmail.com](mailto:mackdfoundation@gmail.com)  
Website: [www.mackdfoundation.org](http://www.mackdfoundation.org)

## Patient Assistance Application

### Healthcare Facility Information

**This page is to be filled out by the healthcare facility ONLY.**

Name of Applicant: \_\_\_\_\_

Name of the facility where treatment will be received: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Healthcare Facility Contact Person: \_\_\_\_\_

Email of Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Treatment Duration: \_\_\_\_\_

Anticipated number of miles roundtrip to treatment for 90 days (please use the calculation below to determine):

$$\frac{\text{_____}}{\text{(Miles roundtrip for 1 trip)}} \times \frac{\text{_____}}{\text{(# of trips for treatment for 90 days)}} = \frac{\text{_____}}{\text{(Anticipated miles for 90 days)}}$$

Applicants must be currently receiving/undergoing radiation or chemotherapy treatments or hospitalized for hospice, treatments, surgery, or complications resulting from Cancer.

**Does this patient meet this requirement?** \_\_\_\_\_

Signature of Contact from Healthcare Facility: \_\_\_\_\_ Date Signed: \_\_\_\_\_

-----  
**Mack D. Foundation, Inc. strives to help as many applicants as possible from the funds raised through our events and donors. Please understand our guidelines below when applying for assistance.**

*"The spirit of God has made me, the breath of the almighty gives me life" ~ Job 33:4*



## **Mack D. Foundation, Inc.**

PO Box 56 ~ Falcon, NC 28342

Phone: (910)980-1501 Fax: (910)892-1418

Email: [mackdfoundation@gmail.com](mailto:mackdfoundation@gmail.com)

Website: [www.mackdfoundation.org](http://www.mackdfoundation.org)

Page 3 of 3

### **APPLICATION GUIDELINES**

- Applicants must be currently receiving/undergoing radiation or chemotherapy treatments or hospitalized for hospice, treatments, surgery, or complications resulting from Cancer.
- Applicants must reside in Harnett, Cumberland, Johnston, or Sampson County in North Carolina.
- Applicants must reapply every 90 days to continue receiving assistance.
- Maximum assistance allowance: Recipient is limited to receive assistance up to 8 times within a 24 month period, whichever occurs first. After a 12 month waiting period a patient may re-apply. Then the maximum assistance allowance will start over.
- Receipts may be required to continue assistance after initial contribution.
- Applications must have healthcare facility information filled out completely which includes a contact and their signature from the healthcare facility.
- Applications must have the patient's signature.
- Applicants must answer each question completely and attach all needed documents in order to be considered.
- Applicant's information and medical history will only be shared with Mack D. Foundation, Inc. Board of Directors unless consent is obtained.
- Mack D. Foundation, Inc. does not discriminate against any person on the basis of race, color, national origin, disability, gender, gender identity, sexual orientation, religious preference, or age in its programs, services, assistance programs and activities.
- Mack D. Foundation, Inc. Board of Director's reserves the right to deny applications based upon funds availability or other circumstances that may arise.
- Applications must be submitted on or before the 15<sup>th</sup> of month to be considered for assistance the following month. (ie: Application deadline January 15<sup>th</sup> for assistance in February)
- Please submit your application by email, fax or by mail to the above address.
- Patient will be notified in writing of acceptance or denial of the application within the first week of the requested assisted month.

**If all of the above guidelines are not met the application will be denied. This page may be kept for your records. Please contact us with any questions regarding application.**

*"The spirit of God has made me, the breath of the almighty gives me life" ~ Job 33:4*