Mack D. Foundation, Inc.
PO Box 56 ~ Falcon, NC 28342
Phone: (910)980-1501 Fax: (910)892-1418
Email: mackdfoundation@gmail.com
Website: 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 _____

Assistance is provided exclusively in the form of Walmart gift cards. These cards may be used to purchase any items except alcohol, tobacco, firearms, or lottery products. Gift cards may also be used for fuel purchases at Walmart and Sam's Club gas stations, as well as at select Murphy gas stations. Payment at the pump is not available; purchases must be made by paying the attendant.

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

Are you currently working while undergoing treatment?	□ Yes	□ No	□ N/A
If working, have you had to reduce hours?	□ Yes	□ No	□ N/A
If not currently working, did you have to take temporary leave or quit?	□ Yes	□ No	□ N/A
Have you ever missed treatment due to transportation difficulties?	□ Yes	□ No	□ 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
Website: 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: _____

Current Diagnosis: _____Diagnosis Date: _____

Current Treatment Type & Plan (**next 90 days**): _____

Current Treatment Date Range (**next 90 days**): _____/_____/_____ to _____/_____/_____

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

_____X_____=_____
(Miles roundtrip for 1 trip) (# of trips for treatment for 90 days) (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.

Mack D. Foundation, Inc.
PO Box 56 ~ Falcon, NC 28342
Phone: (910)980-1501 Fax: (910)892-1418
Email: mackdfoundation@gmail.com
Website: www.mackdfoundation.org

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 complete a new application every 90 days to continue receiving assistance.
- The maximum number of times a patient may receive assistance is 10. (Effective 12/31/2025)
- Receipts may be required to continue assistance after initial contribution.
- Applications must have healthcare facility information filled out completely which includes a contact person 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 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 based on 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 15th of the month to be considered for assistance in the following month (e.g., applications submitted by January 15 will be considered for February assistance).
- Patients will receive written notification of acceptance or denial during the first week of the assistance month.
- Please submit your application by email, fax or by mail to the above address.

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.