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 ______

Please check what is of need:

Household - Grocery	☐ Need	☐ Urgent

Travel - Gas	☐ Need	☐ Urgent

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

Updated 09/30/24

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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.

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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 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 month to be considered for assistance the following month. (ie: Application deadline January 15th 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.

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