



Patient Assistance Program Application

The Outlaw Foundation is a 501(3) c Non-Profit organization which helps patients who are currently undergoing chemo or radiation therapy or who are within one year of completing therapy.

Patient Name _____ DOB _____
 Patient Address _____
 Patient Home Phone _____ Cell _____
 Married _____ Single _____ Widowed _____ Number of Dependents _____
 Male ___ Female ___ Insurance _____
 Cancer Dignosis _____

Gross Monthly Income _____ Proof of Income Received Yes ___ No ___

<u>Income</u>	<u>Monthly</u>	<u>Spouse</u>	<u>Yearly</u>	<u>Notes:</u>
Salary	\$ _____	\$ _____	\$ _____	
Pension	\$ _____	\$ _____	\$ _____	
Social Security	\$ _____	\$ _____	\$ _____	
SSI Supp Income	\$ _____	\$ _____	\$ _____	
Disability	\$ _____	\$ _____	\$ _____	
Unempolyment	\$ _____	\$ _____	\$ _____	
Alimony/Child Sup	\$ _____	\$ _____	\$ _____	
Total Yearly Household Income \$ _____				

References:

Name	Relation / Phone #
1. _____	_____
2. _____	_____
3. _____	_____

Note: If more room is needed please use back of application for References:

Patient has been approved for a total of \$1,200.00 for one year. Effective Date _____

Approved By _____ Date _____

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility for assistance through The Outlaw Foundation. I agree to inform The Outlaw Foundation of any change of condition or circumstances that might impact my eligibility. Any untruthful or fraudulent information provided or my refusal to cooperate with the eligibility process may be grounds for denial of assistance. I also understand that the above information may be provided to other third party patient assistance programs on my behalf.

Patient or Family Signature: _____ Date: _____

Applications can be email or mailed to:

*The Outlaw Foundation
PO BOX 189
Newton Grove, NC 28366*

*Or email to:
Boutlaw32@gmail.com*

*Questions:
Call 1-800-334-3452 x.233
Fax: 910-594-0297*