Phone: 815-363-1189
Email: info@walla-pa-looza.org
Web: www.walla-pa-looza.org

Application for Financial Grant

Walla-Pa-Looza is an organization that organizes and participates in events to raise money to assist cancer patients and cancer research. The monies raised by our events are distributed both locally and nationally. As we strive to support families in local community, please complete the below application for yourself or on behalf of a loved one.

Please be aware that funds are limited and are based on availability

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Relationship to person applying for Grant: ☐ Self ☐ Spouse ☐ Loved One/caregiver ☐ Health care professional

Name and contact information filling out application if other than self: ____________________

PATIENT INFORMATION:

First Name: ____________ Last Name: ____________ Today's Date: ________

Address: ____________________ City, State, Zip: ____________________

Phone Number: Home: ____________________ Cell: ____________________

Email Address: ____

Date of Birth: ____________ If patient is a minor (under 18), name of parent or guardian: ____________

MEDICAL INFORMATION: (MUST be completed by doctor, nurse, social worker or ACS patient navigator ONLY)

Date of Diagnosis: ____________ Primary Cancer: ____________ Stage: ____________

☐ New Diagnosis ☐ Recurrence Is patient in active treatment? ☐ Yes ☐ No

If not in active treatment, indicate frequency of follow-up: ☐ Yearly ☐ Every 6 months Other: _____

Please indicate type of treatment(s) received in past twelve months (check all that apply):
☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative Care ☐ Bone marrow/Stem Cell transplant

HEALTH CARE PROFFESSIONAL INFORMATION:

MD Name: ____________________ Hospital/Clinic Name: ____________________

Address: ____________________ City/State/Zip: ____________________

Phone: ____________________ Fax: ____________________

Name and title of person completing this section if different than above: ____________________

Phone: ____________________ Email: ____________________

Your relationship to person applying for help: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ ACS patient Navigator

Signature of **Medical** Professional: ____________________ Date: ____________________

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Applicant's Name: ________________________________

FINANCIAL ASSISTANCE NEEDS (Please check all that apply):
☐ Transportation ☐ Child Care ☐ Home Care ☐ Medications ☐ Co-Payments/Medical Bills Other: _____

Please provide a brief essay on why a financial grant is needed:

Signature: ____ Date: ____________________________

Relationship to person applying for help:
☐ Self ☐ Spouse ☐ Family Member/caregiver ☐ Health care Professional

Thank You!

Please print, sign and mail the completed form to:
Walla-Pa-Looza
c/o Craig Wallace
4000 Cedar Creek Drive
Johnsburg, Illinois 60051