Hope For Young Adults With Cancer
P.O. Box 16091
St. Louis, MO 63105-6091
www.hope4yawc.org
EIN - 45-2299296

HEALTH CARE PROFESSIONAL INFORMATION (PLEASE PRINT)

DATE: ______________

APPLICANT 'S NAME:___________________________________ **APPLICANT'S DIAGNOSIS** ____________________________

THE APPLICANT IS CURRENTLY BETWEEN THE AGES OF 18 – 40: ________ **YES** _________ **NO**

MD NAME: ______________________________________ **HOSPITAL/CLINIC**: ____

ADDRESS: _______________________________________ **CITY, STATE, ZIP**: ____

PHONE NUMBER: ( ) _______________________________

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (PLEASE PRINT):

NAME: ____

PHONE NUMBER: ( ) ______________________ **E-MAIL ADDRESS**: ____

YOUR RELATIONSHIP TO PERSON APPLYING FOR HELP (PLEASE CHECK):

___________ **DOCTOR** __________ **NURSE** __________ **SOCIAL WORKER** __________ **HOSPITAL PATIENT NAVIGATOR**

SIGNATURE OF MEDICAL PROFESSIONAL: ____

DUE NO LATER THAN APRIL 14, 2017

- **The applicant is applying for financial assistance from Hope For Young Adults With Cancer and we require a physician's verification of their diagnosis. If the applicant is selected, we will follow up to verify this information with a medical professional after required HIPAA forms are received.**