LEAVE A LEGACY FOUNDATION

Greatest Needs Assistance Request Form

Today's Date: _____ **Type of Cancer:** _____

Patient's Name: _____ **Date of birth:** _____ **County:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Person to contact if different than applicant: _____ **Primary Phone:** _____

Type of Assistance Requested:

☐ Gas Card ☐ Meals ☐ Medical Expenses (tests, medications, etc.): _____ ☐ Lodging:_____

☐ Other (please explain):_____

Amount Requested:_____ Date Needed:_____How did you hear about Leave A Legacy:_____

Location of Treatment: _____

Please tell us why you are seeking assistance (We may contact you for additional information if needed):

_____

_____

_____

_____

Completion of form does not guarantee assistance. Assistance may be subject to caps, level of need, or fund availability.
Please email to LLFGreatestNeeds@gmail.com

THIS SPACE IS TO BE COMPLETED BY STAFF ONLY

Person Completing Form if Staff Member:

Date application received: **Entered into spreadsheet:**

Is Funding Available: YES NO **Approved:** YES NO

Amount Requested: _____ **Amount Approved:** _____

List specifically what was approved or the reason why it was not approved below:

_____

_____

_____

Date funding given: Form of funding (check #):