

The Lorie Johnson Foundation
Assistance Fund Application

Please print this entire form and complete both pages.

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

Social Security Number: _____

DAY TIME PHONE: _____ EVENING PHONE: _____

REFERRED BY: _____

HAVE YOU BEEN DIAGNOSED WITH CANCER? YES _____ NO _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

ONCOLOGIST: _____

ADDRESS: _____

PHONE: _____

SURGEON: _____

ADDRESS: _____

PHONE: _____

Please complete the information on the following page:

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SPECIFIC TYPE OF ASSISTANCE REQUESTED:

Travel Need: _____

Living Expense Need: _____

Medical Expenses Need: _____

ANNUAL HOUSEHOLD INCOME: _____

TOTAL HOUSEHOLD ASSETS: _____

TOTAL HOUSEHOLD LIABILITIES: _____

INSURANCE PROVIDER: _____

Please read the following information carefully before signing:

I hereby understand and recognize that the Lorie Johnson Foundation (the "Foundation") is a non-profit organization that is tax exempt pursuant to Internal Revenue Code Section 501c3. The foundation has been established to help women who have been diagnosed with cancer through financial support for medical bills, living expenses, and travel associated with fighting cancer. The Foundation will provide grants based on need and urgency. The Board of Trustees will be responsible for grant decisions as set forth in the bylaws. The Foundation is only authorized to offer assistance to those individuals who have demonstrated financial need, which is not covered by insurance. I hereby certify that the financial information set forth in this application concerning my annual income, assets, liabilities, and insurance provider is true and accurate and that the purchase of goods and services that I have requested of the Foundation to purchase on my behalf cannot be purchased by me or my family without incurring financial hardship. I further certify that I have been diagnosed with cancer and that I and my family do not have insurance coverage which would pay for goods and services that I have requested the Foundation to purchase on my behalf. I understand that if any of the information set forth above is false I am subject to penalty.

Date: _____ **Signature:** _____

My signature above grants permission for Foundation Representatives to contact my physician(s).

Print, complete, and mail the completed application to: The Lorie Johnson Foundation P.O. Box 381284 Birmingham, AL 35238