Paternostro Family Foundation
PO Box 1862
Williamsport, PA 17703

paternostrofamilyfoundation@comcast.net

REQUEST FOR FINANCIAL ASSISTANCE – 2018

_____
Name (Last, first, middle initial)

_____
Street address, City, ST, ZIP Code

_____
Primary phone number | Email Address

HEALTH CARE PROFESSIONAL SUBMITTING REQUEST

As a referring hospital, I have knowledge that this applicant is a cancer treatment patient under medical care and, to the best of my knowledge, this individual or their family appear to be in need of financial assistance. I have reviewed the criteria for assistance through the Paternostro Family Foundation and believe this applicant meets the criteria.

_____
Name

_____
Phone Number

_____
Signature of Health Care Professional

The above information is true and correct and I authorize the above-named health care professional to speak on my behalf as it pertains to my request for financial support through the Paternostro Family Foundation.

_____
Signature of Applicant

Type of Request (Requests may be granted up to $200.00 per applicant, based on need.)

☐ Gas Card (Sheetz)
☐ Grocery Card (Weis, Giant)
☐ Utility Payment*
☐ Other*

*Payments will be made directly to provider (landlord, bank, utility company, etc.) Copies of bills must be attached.

Amount of request: $_____.00

Please use the space below to provide additional information related to this request for financial assistance.

_____

_____

_____

_____

For Administrative Use Only: _____ _____
Date received

Action taken _____ _____