

# The Barlow Foundation Assistance Request

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
ZIP: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Number of People in Household: Adults: \_\_\_\_\_ Children: \_\_\_\_\_ (under 18 years old)

Has the patient been diagnosed with Cancer? Yes / No Date diagnosed: \_\_\_\_\_

Assistance needed most: (rate starting with 1 for most needed going down in number to least needed)

- |  |   |
|--|---|
| <input type="checkbox"/> Fuel cards for medical travel         | <input type="checkbox"/> Non-Prescription Medications |
| <input type="checkbox"/> Out of Town Housing / Hotels          | <input type="checkbox"/> Parking Fees                 |
| <input type="checkbox"/> Scarves / Wigs /Hats (chemo patients) | <input type="checkbox"/> Utilities                    |
| <input type="checkbox"/> Out of Town Food                      | <input type="checkbox"/> Mortgage / Rent              |
| <input type="checkbox"/> Travel to Out of State Care Provider  | <input type="checkbox"/> Groceries                    |
| <input type="checkbox"/> Pet Care / Boarding                   | <input type="checkbox"/> Prescription Medications     |
| <input type="checkbox"/> Child Care                            | <input type="checkbox"/> Loans Personal / Auto / Etc  |
| <input type="checkbox"/> Peer Support                          | <input type="checkbox"/> Resources                    |
| <input type="checkbox"/> Other Description of Other: _____     |   |

*By completing and signing the request I am verifying that **all** information is accurate and true. I understand that should I falsify any part or parts of this document I will lose any funding that is promised and will be liable for the amount of any funds given, plus any filing, investigative, or legal costs accrued plus interest, by **The Barlow Foundation**.*

*I understand that this is an **APPLICATION** for assistance and does not guarantee any disbursement of funds. No Agent, Board Member, or other person representing or implying they represent The Barlow Foundation can guarantee **any** disbursement of funds. The Board of Officers **must** review every application for consideration and approval of disbursement of any funds. The Barlow Foundation will try to meet requests to some ability, but may only be able to meet a portion of the request, based on the number of requests, and funds available.*

*I understand that I may be requested to supply additional documentation, account information, etc. My failure to supply the requested documents in a timely matter may be cause for dismissal of the request for assistance or delay of consideration by the Board of Officers.*

***A letter is required from a medical provider on their letterhead with this application that includes a current diagnosis, and additional information of referrals if outside of the providers office.***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return the application to: The Barlow Foundation  
3406 Burlington Ave.  
Evans, CO 80620

Phone contact Brian Spencer: (970)302-6209

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**The Barlow Foundation Use only**

**Received by:** \_\_\_\_\_  
**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Reviewed by Board of Officers**      **Date:** \_\_\_\_\_