The Kimberly Walton Foundation exists to provide financial assistance to patients and their families suffering from Hodgkin's lymphoma and/or leukemia. To apply for assistance, you must be a U.S. resident and be currently experiencing a financial burden due to your diagnosis of Hodgkin's lymphoma and/or leukemia. All application information is confidential. For more information, please visit our website at www.kimberlywaltonfoundation.org.

Recipient Application

Patient Information	
Name	
Street Address	
City / State / Zip Code	
Country	
County	
Home Phone	
Work or Cell Phone	
E-Mail Address	
Gender	☐ Male Female
Date of Birth	
Do you have health insurance?	☐ Yes ☐ No
Do you have a prescription drug plan?	☐ Yes ☐ No
Do you have Medicare?	☐ Yes ☐ No
Are you currently receiving assistance from another charity program? If yes, which program?	☐ Yes ☐ No ______________________
Are you at least 18 years of age? If no, please provide Parent/Guardian First and Last Name.	☐ Yes ☐ No ______________________

Reason for Request

Please tell us why you are applying for financial assistance through The Kimberly Walton Foundation and what your specific needs are such as child care, pet care, medical bills, etc.

Emergency Contact	
First and Last Name	
Phone (if different from above)	
Email Address	
Relationship to patient	

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a recipient, any false statements, omissions, or other misrepresentations made by me on this application may result in denial of my application.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this foundation to provide equal assistance without regard to race, color, religion, national origin, gender, sexual preference, or age.

Thank you for completing this application form.

~To be completed by the patient's doctor~

****Please note: signatures must be original; stamps, photocopies, or initials will not be accepted.****

Completed by Patient's Doctor	
Patient Diagnosis	
Date of Diagnosis	
Hospital/Clinic Name	
Hospital/Clinic Address	
City / State / Zip Code	
Phone	
Physician Signature	
Physician Name (Please Print)	
Physician License #	
Date	