



ROFOUNDATION

Assisting patients and families with unexpected transportation expenses

ASSISTANCE APPLICATION

Patient Information:

Must reside within **35 miles of Dunkirk, NY**

Patient's Name: _____

Address: _____

Phone: _____
(Best number to reach you)

Email: _____

Patient Caregiver (If Applicable)

Your Name: _____

Relationship to Patient: _____

Phone: _____

Email: _____

Name & Location of Treatment Facility or Hospital:

This application MUST be signed and approved by attending Physician or Primary Doctor.

Physician: _____

Phone: _____

(Signed)

(Print)

Type of Assistance Needed: *Check all that apply*

Gas [] Lodging [] Food []

Please include comments or other information here:

I hereby confirm that I have provided within this application form all requested information to the best of my knowledge.

Signature

Date

Mail this application to:

RO Foundation

c/o NCCF

212 Lake Shore Drive West
Dunkirk, New York 14048

Phone: 716-366-4892

Email: app.rofoundation@gmail.com

Web: www.nccfoundation.org

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