Healing Journey Foundation

Healing Journey Foundation – Patient Assistance Application

The Healing Journey Foundation offers compassionate support to patients in active cancer treatment who face financial and emotional challenges. Please complete this application to request assistance through one or more of our programs. Applications must be verified by your oncology care team.

Patient Information

- Full Name: _____
- Date of Birth: _____
- Address: _____
- City: _____ State: ___ ZIP: _____
- Phone: _____ Email: _____ Preferred Contact: _____
- Oncology Center: _____ Physician: _____

Diagnosis & Treatment Verification

- Cancer Type: _____
- Current Treatment: _____
- Verified by Oncology Office: _____ Date: _____

Financial Information

- Employment Status: _____
- Household Income Range: 0-50,000 50000-100000, 100000-1500000
- Do you Rent or Own your home: _____

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- Insurance Coverage: _____
- Other Assistance Received: _____

Select the Fund(s) You Are Applying For

Fund	Description
○ **Nourish & Heal Meal Program**	Provides 5 fresh, nutritious meals (Clean Eatz, Lancaster) per chemo cycle to patients in active chemotherapy who are facing financial, social, and nutritional distress.
○ **Vital Needs Fund**	Offers grocery and gas gift cards to ease daily burdens.
○ **Styled with Strength**	Help patients regain confidence with financial assistance for wigs, in collaboration with Classic Images Salon in Lititz
○ **Healing Touch Fund**	Supports access to medical massage therapy to relieve pain and stress. In collaboration with Debra Heagy, Licensed Oncology Massage Therapist, Lancaster Pa
○ **Peace of Mind Fund**	Provides counseling services to support emotional healing. In Collaboration with Lindsay Webb, LPC, Lancaster Pa.
○ **Empowered Care Fund**	Assists with the cost of durable medical equipment like walkers, shower chairs, and compression garments.

Patient Statement of Need

Please briefly describe your current situation and how this assistance would help:

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Authorization & Consent

I authorize Healing Journey Foundation to contact my treatment facility for verification and understand that assistance is subject to availability and intended purpose. By signing below, I affirm the information provided is accurate.

- Patient Signature: _____ Date: _____
- Navigator/Social Worker Signature: _____ Date: _____

Submission Information

If you prefer not to submit electronically, please submit completed applications via mail to: Healing Journey Foundation Attn: Patient Assistance, 703 Lampeter Rd Lancaster PA 17602.

Applications are reviewed weekly. Approved applicants will be contacted directly. If additional information is needed, we will reach out to you at the phone number or email you provided.