

# Cancer Outreach Foundation

## APPLICATION FOR ASSISTANCE

IN SOUTHWEST VIRGINIA AND NORTHEAST TENNESSEE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTY: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

MARITAL STATUS:

(Please Circle) MARRIED SINGLE DIVORCED WIDOWED SEPARATED

CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_

CANCER TYPE: \_\_\_\_\_ TREATMENT TYPE: \_\_\_Radiation \_\_\_Chemo \_\_\_Other

TREATMENT LOCATION: \_\_\_\_\_

WHO REFERRED YOU TO CANCER OUTREACH FOUNDATION?

\_\_\_HOSPITAL \_\_\_PHYSICIAN \_\_\_OTHER

EMPLOYMENT INFORMATION:

EMPLOYER NAME: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_

INCOME INFORMATION (PER MONTH) :

SALARY \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_ DISABILITY \_\_\_\_\_

HOW MANY PEOPLE LIVE IN THE HOUSEHOLD? \_\_\_\_\_

DO YOU OR SPOUSE HAVE MEDICAL INSURANCE? \_\_\_YES \_\_\_NO

\_\_\_SSI \_\_\_MEDICARE \_\_\_MEDICAID

NAME OF INSURANCE COMPANY: \_\_\_\_\_

AMOUNT OF CO-PAY REQUIRED: \_\_\_\_\_

HOUSING: \_\_\_OWN \_\_\_RENT \_\_\_OTHER (Specify) \_\_\_\_\_

SPECIAL CIRCUMSTANCES: \_\_\_\_\_

PATIENT SIGNATURE OR PERSON TAKING CALL: \_\_\_\_\_

DATE: \_\_\_\_\_