CANCER OUTREACH FOUNDATION

Help Today. Hope Always.

www.CancerOutreachFoundation.com

APPLICATION FOR ASSISTANCE

Name:_____ Date of Birth:_____

Mailing Address:_____

City:_____State:_____Zip Code:_____

Phone:_____County:_____*COUNTY NEEDS TO BE ON ASSISTANCE LIST*(See Other Form)

Marital Status: (Please Circle) Married Single Divorced Widowed Separated

Emergency Contact Name:_____Phone:_____

Physician Name:_____Phone:_____

Physician Address:_____

Cancer Type:_____Treatment Type:_____Radiation_____Chemo_____Other

Treatment Location:_____

Pharmacy currently use:_____ Phone:_____

Who referred you to Cancer Outreach Foundation?____Hospital_____Physician_____Other_____

Employer Name:_____Spouse's Employer:_____

HOUSEHOLD Income Information (Per Month):_____**Provide statements for the following that apply**:

Salary $_____* Social Security $_____* Disability $_____*

IF you are a MEDICAID cardholder, please provide a copy of your card only – no other documentation required

Housing:_____Own _____Rent _____Other (Specify):_____How many living in household?_____

Amount of Mortgage/Rent Monthly: $_____

Do you or your spouse have medical insurance? _____Yes_____No

_____SSI _____Medicare _____Medicaid

Name of Insurance Company:_____Amount of Co-Pay Required:_____

Special Circumstances:_____

Patient Signature/Authorized Trustee Signature:_____**Date**:_____