UNION COUNTY CANCER SOCIETY
FUNDED BY THE UNITED WAY OF UNION COUNTY

Application for Financial Assistance

Patient Information
(Please Print)

Last name: ______________________ First Name: ______________________ Date: __________

Address: ______________________ City/State/Zip: ______________________

Phone: Home ( ) ______________________ Work ( ) ______________________

Date of Birth: ______________ Age: ________ Ethnicity: ______________________
(Please specify)

☐ Male ☐ Female
☐ If Patient is a minor, name of parent or guardian: ______________________

UCCS use only: UCCS# ______________________

Financial Information

TOTAL FAMILY INCOME

Currently Employed ☐ Yes ☐ No

Number in Household: ______________

Income Source (please check all that apply):

☐ Spouse

☐ Social Security (retirement)
☐ Alimony
☐ Salary
☐ Pension
☐ Public Assistance Short Term
☐ Disability
☐ Child Support
☐ Family/Friends provide support
☐ SSD (Disability)
☐ Unemployment
☐ SSI
☐ Sick Leave Pay

Health Insurance Information

Do you have health insurance? ☐ Yes ☐ No

If yes, please indicate type of insurance: (check all that apply)

___Medicaid ___Private Insurance ___Medicaid Pending ___Public Health Insurance ___Medicare Only

___VA Program ___Medicare plus Medicaid ___Charity Care ___Medicare plus other supplemental coverage

___Emergency Medicaid

Are prescription drugs covered? ☐ Yes ☐ No

Basic Financial Assistance: Check all that apply. Please be aware that our financial assistance is not for living expenses such as rent, mortgages, utility payments and food, or medical bills. If you need this assistance, we may be able to refer you to a local agency that can help.

☐ **Mileage Reimbursement** ☐ **Supplies** ☐ **Misc.**

☐ **Prescription Medication** ☐ **Wig**

Signature ______________________ **Print Name** ______________________

Relationship to Person applying for Help:

☐ **Other Relative** ☐ **Spouse** ☐ **Friend** ☐ **Caregiver** ☐ **Self**

To be Completed by your Doctor, Doctor's Office or delegated personnel

Date of Diagnosis: ____________________ Primary Cancer: ______________________________

Stage of Cancer: ____________ ☐ New Diagnosis ☐ Recurrence In Active Treatment? ☐ Yes ☐ No

If Yes, please indicate type of treatment (check all that apply):

☐ ChemotherapyRadiation ☐ Clinical Trial ☐ Surgery ☐ Hormonal ☐ Paliative Care

☐ Bone Marrow/Stem Cell Transplant ☐ Complementary/Alternative

If No, is Post Treatment Follow Up Needed? ☐ Yes ☐ No

If Yes, please indicate type of follow up: ☐ Yearly ☐ Every Six Months ☐ Other ____________

MD Name: ______________________ Hospital/Clinic: ______________________

Address: ____

City/State/Zip: ________________ Phone: ______________ Fax: ______________

Signature of person completing this section: ______________________________

Print Name/Title: ____

Phone (if different than above): ______________ E-mail address: ______________________

Relationship to Person Applying for Help: ☐ Doctor ☐ Nurse ☐ Social Worker

Thank you for completing this application. We will review this information and contact the person requesting help. Funds are limited and based on availability. All information is strictly confidential. Please mail completed form to: Union County Cancer Society, Inc.;
P.O. Box 557;
Marysville, OH 43040;

if you have any questions, please call (937) 642-3910.

June, 2009