WABASH COUNTY CANCER SOCIETY

A United Fund Agency

Date Rec'd _____

Decision _____

Patient Notified on _____

By _____

This form is an acknowledgment of your request for financial aid from the Wabash County Cancer Society. Please answer the following questions and return both copies to the Society in the enclosed envelope. After careful consideration, your application will be acted upon and you will be advised accordingly.

Name _____ Birthdate _____ Age _____

Address _____ Phone _____

RELATIVES

RELATION	NAME	ADDRESS	EMPLOYER
Wife			
Husband			
Mother			
Father			
Children			
Other			

Are any relatives helping you now? _____ Who? _____

Do you have Hospitalization Insurance? _____ Drug Card? _____ Do you receive Aid from Welfare? _____

Have any other Income? _____ YES / NO _____ If you are 65 o have Medicare? Plan A _____ Plan B _____

Estimate your total monthly income: $ _____

Your physician Name _____

Address _____

Would you be interested in:

A Support Group? _____ Additional Literature? _____ Sick Room Equipment? _____

Feel free to add any further information you think might be of help to us. Use reverse side of paper if necessary. All information provided will be held in strict confidence. False or misleading information or refusal to provide information needed to evaluate your application could result in rejection of assistance by the Wabash County Cancer Society, Inc.

Your Signature _____ Date _____

If this form is complete by someone other than the patient, please give name and address.

BELOW MUST BE COMPLETED

Pharmacy _____ Phone Number _____

Diagnosis by the Attending Doctor _____

Physician's Signature _____