WABASH COUNTY CANCER SOCIETY, INC

A UNITED FUND AGENCY

PO BOX 144, NORTH MANCHESTER, IN 46962

Application For Assistance

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

Name_____DOB_____AGE_____

Address_____Phone_____(HOME / CELL)

FAMILY/HOUSEHOLD INFORMATION

RELATIONSHIP	NAME	ADDRESS

Please provide the following information:
Are any relatives helping you financially now? **YES / NO** If so, how much?_____
Do you have Insurance? **YES / NO** If so, whom?_____
Prescription Card? **YES / NO** Do you have Medicaid? **YES / NO** Do you have Medicare? **YES / NO**
Plan A? **YES / NO** Plan B? **YES / NO**
Your total monthly income: $_____ Any other sources of income? **YES / NO** If so, how much?_____

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 completed by someone other than the patient; please provide name, phone # and address:

SIGNATURE_____**PHONE**_____**ADDRESS**_____

!!!!!!!!!! BELOW MUST BE COMPLETED AND SIGNED BY ATTENDING PHYSICIAN !!!!!!!!!!

(Be advised; failure to have this part completed and signed could result in delay or denial of your application)

Attending Physicians Name_____

Address:_____**PHONE**_____

Patient Diagnosis/Type of Cancer_____

Physician's Signature_____**DATE**_____

----------For Internal Use Only Below This Line----------

Date Received:_____**Decision Made:**_____**Patient Notified**_____**BY:**_____
Additional Notes: