APPLICATION FOR ASSISTANCE

Date: _____

Name: _____

Address: _____

County of Residence: _____

City: _____ **State/province:** _____

Country: _____ **Zip/postal code:** _____

Home Phone#: _____ **Work Phone#:** _____

Cell Phone#: _____ **ALT Phone#:** _____

Place of Employment: _____

Employment Address: _____

City: _____ **State/province:** _____ **Zip/postal code:** _____

Total Income: _____ **Medicaid/ Medicare Eligibility:** _____

Country of Citizenship: _____ **Number of Years in US:** _____

Name of Primary Care Physician: _____

Address: _____

City: _____ **State/province:** _____

Country: _____ **Zip/postal code:** _____

Office Phone: _____ **Fax Number:** _____

Oncologist: _____

Address: _____

City: _____ **State/province:** _____

Country: _____ **Zip/postal code:** _____

Office Phone: _____ **Fax Number:** _____

Contact: _____

Oncologist: _____

Course Of Treatment : _____

APPLICATION FOR ASSISTANCE

PRINT CLIENT NAME: _____

SIGNATURE: _____ **Date:** _____

YOU MAY BE ASKED TO PROVIDE VERIFICATION OF THE OF THE FOLLOWING:

I. **VERIFICATION LETTERS FROM PRIMARY PHYSICIAN AND ONCOLOGIST**
II. **PROOF OF MEDICAL INSURANCE**
III. **NOTARIZED COPY OF PASSPORT OR ALIEN CARD**
IV. **MEDICAID ELIGIBILITY**
V. **VERIFICATION OF IMMIGRATION STATUS**
VI. **PROOF OF INCOME**

OFFICIAL USE ONLY

Telephone interview or interview in person maybe required to determine further consideration.

RECOMMENDATION: _____

_____

APPROVING OFFICIAL NAME: _____

SIGNATURE: _____ **Date:** _____

This form was sent for approval via:

☐ Fax
☐ Email
☐ Internet
☐ Mail