BOONE COUNTY CANCER SOCIETY

AWARENESS. SERVICE. EDUCATION.

117 West Elm Street, Lebanon, IN 46052
Phone: 765-482-2043 **Fax:** 765-481-2262
Email: boonecancersociety@gmail.com
Web: www.boonecountycancersociety.org

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Information **(please print clearly)**

First name: ________________________ Last Name:__________________________ today's Date:_____________

Address:______________________________________ City, State, And Zip:
____

Phone number: Home: (______) ____________________________ Work: (_______) ________________________

Cell: (______)_____________________________ Email Address: ____

Date of birth: ____________ if patient is a minor (under 18) name of parent or guardian:_________________________

_____ Male ____ Female Ethnicity: ____White ____ African American ____ Latino ____ Asian Other

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MEDICAL INFORMATION *****THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL PATIENT NAVIGATOR ONLY**

Date of diagnosis: _______________ Primary Cancer: _______________________ Current Stage _____________

____ new diagnosis ____ Recurrence **Is patient in current treatment?** _____Yes _____No

If not in active treatment, indicate frequency of follow-up: ____Yearly ____ Every six months _____Other
Please indicate type of treatment(s) received in past twelve months (check all that apply)

__Chemotherapy ___ Radiation ____ Surgery ___ Hormonal ___Palliative care ___Bone Marrow/stem cell transplant

***** PLEASE COMPLETE ALL FIELDS ABOVE*****

MD name:_______________________________________ Hospital/Clinic:________________________________

Address: ____City,State,Zip:___________________________________

Phone: (_____)_____________________ Fax: __________________________________

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print)

____

Phone: (_____)___________________________ Email: ____

Your relationship to person applying for help: _____ Doctor _____ Nurse_______ Social Worker _____ACS Hospital Patient Navigator

Signature of MEDICAL Professional: ____

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED

PATIENT'S NAME:____ DOB:____________________

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE

HEALTH INSURANCE INFORMATION

Does the patient have health insurance: _________ **Yes** __________ **No**

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

___Private Insurance ___Medicaid ___Medicare __Medicare plus Medigap ____Charity care ___VA program

Are prescription drugs covered? _____Yes _____No

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ____ Yes _____ No Number of people in household: ______________

FAMILY INCOME SOURCES (please check all that apply)
____ Social Security (Retirement) ____Salary _____Pension ____Unemployment
____ Public Assistance ____Short term disability ______SSD (Disability) _____SSI
____Family/family provide support ______Other – specify__________________________

****Application will not be processed if this information is not provided****

Please be aware that funds are limited and based on availability as well as on meeting Boone County Cancer's eligibility requirements.
Our assistance is NOT for living expenses such as rent, mortgages, utility payments, or food. If you need this type of assistance, we will be happy to refer you to a local agency for help.

FINANCIAL ASSISTANCE NEEDS (Check all that apply):
I need your help with the following cancer-related expenses:

Name of person completing this section (please print)____

____Transportation _____Cancer related medications ____Pain medication ____Lymphedema Supplies (Breast Cancer)

____Wigs/Prosthesis ______Co-Pays _____Mammogram Assistance

Signature: ____ Date: ____________________________

Relationship to person applying for help: ____Self ___Spouse ___Family Member/Caregiver ____ Health Care Professional

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THANK YOU.
FAX THIS FORM TO (765)481-2262 OR MAIL TO: Boone County Cancer Society, 117 West Elm Street, Lebanon, IN 46052
Boone County Cancer Society will review this information and contact the person requesting financial assistance.
ALL information is strictly confidential and is for Boone County Cancer Society use only.

Supported in part by

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