Cancer Association of Champaign County

P.O. Box 38125, Urbana, Ohio 43078 937-653-3899 www.cancerassociationorchampaigncounty.com

APPLICATION FOR ASSISTANCE

NAME_____ DATE OF BIRTH _____

SSN _____ PHONE_____ WORK/CELL PHONE _____

ADDRESS_____

CITY_____ ZIP _____

EMPLOYER _____ADDRESS_____

SPOUSE'S NAME _____SPOUSE'S EMPLOYER _____

OTHER FRIEND OR RELATIVE _____PHONE _____

PREFERRED PHARMACY _____

INSURANCE OR OTHER BENEFITS AVAILABLE:

- ☐ GROUP OR PRIVATE INSURANCE (GIVE NAME OF CO) _____
- ☐ MEDICARE (GIVE NUMBER) _____
- ☐ MEDICAID _____
- ☐ VETERAN'S BENEFITS _____
- ☐ PRESCRIPTION DRUGS BENEFITS (% ALLOWED) _____
- ☐ PUBLIC ASSISTANCE _____
- ☐ AMERICAN CANCER SOCIETY _____

ATTENDING PHYSICIAN: _____

ADDRESS: _____

REFERRED TO CACC BY: _____

I FIND THE ABOVE INFORMATION TO BE CORRECT AND UNDERSTAND THAT ANY PAYMENT MADE BY CACC WILL BE MADE ONLY ON AMOUNTS DUE AFTER INSURANCE AND OTHER BENEFITS AVAILABLE TO ME HAVE BEEN CREDITED. NO CACC PAYMENTS WILL BE MADE DIRECTLY TO ME.

I UNDERSTAND THAT I MAY BE ASKED TO ANSWER A CONFIDENTIAL PATIENT QUESTIONNAIRE FOR THE PURPOSE OF GIVING FEEDBACK TO THE CACC.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

An Affiliate Member of United Way

LEAVE A LEGACY®