Caswell County Cancer Resource Fund

APPLICATION FOR ASSISTANCE

Please complete the following and return it to:
Caswell Family Medical Center, Attn: Lou Ann Reaves
Fax: 336-694-7511

Where did you get your application? _____

Demographic Information:

❑Dr. ❑Miss ❑Mr. ❑Mrs. ❑Ms.

Name: (Last) _____ (First) _____ (MI) ____ (Previous) _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone (Home): _____ - _____ - _____ (Cell): _____ - _____ - _____ (Work): _____ - _____ - _____

Date of Birth: ____ / ____ / _____

Employment Status: ❑Full Time ❑Part Time ❑Not Employed ❑Self Employed ❑Retired ❑Active Military

Employer Name (if applicable): _____

Race: ❑American Indian/Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Black/African American ❑White ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Declined

Language: ❑English ❑Spanish ❑Other: _____

Email Address: _____

Do you have health insurance? ❑None/Uninsured ❑Medicaid ❑Medicare ❑Private ❑Employer ❑Tricare

Caregiver's Information (if applicable):

Name: (Last) _____ (First) _____ Phone: _____ - _____ - _____

Caregiver's relationship: ❑Legal Guardian ❑Power of Attorney ❑Other

Medical Information:

Do you have a current cancer diagnosis? ❑Yes ❑No

If "yes", what kind/type: _____

Approximate Date of Diagnosis: ___ / ___ / _____

Oncology Doctor's Name: _____

Treatment Center: _____

Financial Information:

Household Net Monthly Income: $ _____ Number of People in House: _____

Source *(Check all that apply)*:

❑Wages/Salaries
❑Disability or SSI
❑Retirement/Social Security
❑Investments (Stocks, Bonds, Rental Property, etc.)
❑Spousal Support, Alimony, or Child Support

Proof of income is not automatically required, however, may be requested at which time failure to provide verification of any of the financial information you've listed above may result in denial of your application.

Requested Assistance:

(Check all that apply)

❑Transportation
❑Durable Medical Equipment
❑Other
❑In-home Respite Care
❑Doctor/Hospital Copay Assistance
❑Prescription Assistance
❑Prescribed Nutritional Supplement

Please describe your need and be as specific as possible. *Example: "I have a car, but don't have money to buy gas to attend my out-of-town cancer treatment appointment on next Tuesday" or "I need a wheelchair to use in my home because my cancer treatments make it difficult for me to move around".*

_____

_____

_____

_____

_____

_____

_____

_____

_____ *(Continue on another sheet if necessary)*

CERTIFICATION:

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Guardian) Signature: _____ **Date:** _____ **/** _____ **/** _____

FOR OFFICE USE ONLY:

Application Status: ❑Approved ❑Declined

If "Approved", list services provided and costs. If "Declined", explain why. _____

_____

_____

Signed: _____ Date: ____ / ____ / _____