CANCER ASSOCIATION of SPARTANBURG & CHEROKEE COUNTIES, INC.
~ Caring. Nurturing. Giving. ~

295 E. Main St. Suite 100, Spartanburg, SC 29302
PO Box 1582, Spartanburg, SC 29304
864-582-0771 FAX 864-583-6123
Email: info@cancerassociation.org Updated 8/10/2017

Date: _____ **Height:** _____ **Weight:** _____

County: ☐ Spartanburg ☐ Cherokee ☐ Union ☐ Other _____

First Name: _____ **Middle Initial:** _____ **Last Name:**_____

Date of Birth:_____/_____/_____ **Age** _____ **Sex:** ☐ Male ☐ Female **Spouse:** _____

Mailing Address:_____

City:_____ **State** _____ **ZIP**_____

Home Phone (____)_____**Cell Phone** (____)_____ **Email** _____

Race: ☐ Caucasian (White) ☐ African American (Black) ☐Hispanic/Latino ☐ Other _____

Emergency Contact _____ **Relationship:** _____

Home Phone (____)_____ **Cell** (____)_____

Oncologist's (Cancer Dr.) Name:_____ **Phone Number:**_____

Cancer Diagnosis 1:_____ (date diagnosed: _____)

Cancer Diagnosis 2:_____ (date diagnosed: _____)

Treatment: **Chemo: How many times per month:** _____ **# Months:** _____ **Start Date:**_____

Radiation: How many times per month: _____**# Months:** _____ **Start Date:**_____

Where will you be taking your chemo/radiation? ☐ **Spartanburg** ☐ **Gaffney** ☐ **Pelham** ☐ **Greer** ☐ **Other** _____

Are you a Smoker? ☐ **YES** ☐ **NO** **Veteran in Household?** ☐ **YES** ☐ **NO**

Assistance Requested

Choose One: ☐ Nutritional Supplements ☐ Treatment Transportation Allocation [Fuel Card] *(during chemo/radiation only)*
☐ Cancer Prescription Allocation

Other Assistance: ☐ Home Care Supplies (bed pads, diapers, etc.) ☐ Wig ☐ Bra ☐ Breast Prostheses
☐ Ostomy Supplies ☐ Hospital Equipment (wheelchair, walker, bedside commode, etc.)

IN ORDER TO BETTER SERVE YOU, THE FOLLOWING INFORMATION MUST BE COMPLETED:

Estimated Total Household Income:
☐ $0-24,120 ☐ $24,121-32,480 ☐ $32,481-40,840
☐ $40,841-49,200 ☐ $49,201-57,560 ☐ $57,561 and up

Number in Household: _____ **Major Medical Insurance** ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ None

Employment: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired

OFFICE USE ONLY:

Allocation: _____ Notes: _____

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Patient Name (please print): _____

I do hereby give permission for the Cancer Association of Spartanburg & Cherokee Counties, Inc. to acquire medical information from the referring physician for patient assistance.

_____
Applicant or Representative Signature (If Patient Under the Age of 18 See Below)

_____ _____
Parent/Guardian Name (Please Print) Parent/Guardian Signature if Patient Under 18

_____
Witness Signature

_____
Date