CANCER ASSOCIATION of SPARTANBURG & CHEROKEE COUNTIES, INC.

~ Caring. Nurturing. Giving. ~

139 South Dean St. Spartanburg, SC 29302
Mailing: PO Box 1582, Spartanburg, SC 29304
Phone 864-582-0771 FAX 864-583-6123
Email: info@cancerassociation.org

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

County of Residence: ☐ Spartanburg ☐ Cherokee

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

Preferred Name _____ **Date of Birth:** _____ **Sex:** ☐ Male ☐ Female ☐ Other

Spouse/Significant Other: _____

Physical Address _____

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

Mailing Address (If different) : _____

Cell Phone _____ **Home Phone** _____ **Email** _____

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

Emergency Contact _____ **Relationship:** _____

Home Phone _____ **Cell** _____

Oncologist's (Cancer Dr.) Name: _____

Cancer Type : _____ **Estimated date diagnosed:** _____

Doctor Group: ☐ Spartanburg Regional/Gibbs/MGC ☐ Prisma Cancer Institute ☐ VA Hospital/Doctor

☐ Other Cancer Group (MUSC, Bon Secours) ☐ Other Non-Cancer ☐ Hospice Group ☐ Urology Group

Are you taking? ☐ Chemo ☐ Radiation ☐ Immunotherapy **Are you a Smoker?** ☐ YES ☐ NO

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

Assistance Requested (check all that apply)

☐ Nutritional Supplements (Boost)
☐ Treatment Transportation Allocation [Fuel Card] *(during chemo/radiation/immunotherapy; oral doesn't count)*

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

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

 # in household: _____ **Estimated Total Household Income:** $ _____ (choose one): ☐ per year ☐ per month

Major Medical Insurance ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ None

Employment: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Permanently Disabled ☐ Medical Leave ☐ Retired

☐ Student **Employer/School**: _____

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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.

_____
Signature

If other than the patient signing:

_____ _____
Parent/Guardian/Representative Name (Please Print) Relationship to Patient

_____
Date

_____
Employee Signature

_____
Date

Updated 7/1/2024