

**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:**  \$0-24,280  \$24,281-32,920  \$32,921-41,560  
 \$41,561-50,200  \$50,201-58,840  \$58,841 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:** \_\_\_\_\_



295 E. Main St., Suite 100, Spartanburg, SC 29302  
PO Box 1582, Spartanburg, SC 29304  
864-582-0771 Fax 864-583-6123  
[www.cancerassociation.org](http://www.cancerassociation.org)  
Email: [info@cancerassociation.org](mailto:info@cancerassociation.org)

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