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 7/31/2018

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

County of Residence: ☐ Spartanburg ☐ Cherokee ☐ Union ☐ Other _____

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

Date of Birth:_____/_____/_____ **Sex:** ☐ Male ☐ Female ☐ Other

Spouse/Significant Other: _____

Mailing Address:_____

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

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

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

Emergency Contact _____ **Relationship:** _____

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

Oncologist's (Cancer Dr.) Name:_____

Cancer Diagnosis 1:_____ (date diagnosed: _____)

Cancer Diagnosis 2:_____ (date diagnosed: _____)

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

☐ Other Cancer Group (MUSC, St. Francis) ☐ Other Non-Cancer ☐ Hospice Group ☐ Urology Group

Are you taking? ☐ Chemo ☐ Radiation **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 ☐ Counseling
☐ 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 Living in Household: _____

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

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

Office Use Only:

Allocation: _____

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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