

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

County of Residence: Spartanburg Cherokee Union Other _____

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

Assistance Requested (check all that apply)

- Nutritional Supplements (Ensure)
 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:** \$0-27,180 \$27,181-36,620 \$36,621-46,060
 \$46,061-55,500 \$55,501-69,940 \$69,940 + up

Major Medical Insurance Private Insurance Medicare Medicaid None

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

Student **Employer/School:** _____



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

Email: 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.

Signature

If other than the patient signing:

Parent/Guardian/Representative Name (Please Print)

Relationship to Patient

Date

Employee Signature

Date