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 09/04/2020

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: ____

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 Type 1:____ (date diagnosed: ____________________)

Cancer Type 2 (if applicable):_______________________________________ (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:

 # in household: _____________ **Estimated Total Household Income:** ☐ $0-25,520 ☐ $25,521-34,480 ☐ $34,481-43,440 ☐ $43,441-52,400 ☐ $52,401-61,360 ☐ $61,361 + up

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

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

☐ Student **Employer/School**: ____

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 other than patient signing:

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

____
Date

____
Witness Signature

____
Date