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 9/4/2020

HOSPICE APPLICATION FOR NUTRITIONAL SUPPLEMENTS

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

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

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

Preferred Name _____ **Email** _____

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

Spouse/Significant Other: _____

Mailing Address: _____

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

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

Name of Hospice Group: _____ **Main Phone:** _____

Hospice Representative: _____ **Cell Phone:** _____

On hospice care due to cancer diagnosis? ☐ Yes ☐ No

Cancer Diagnosis 1: _____ (date diagnosed: _____)

Veteran in Household? ☐ **YES** ☐ **NO**

Other Assistance Requested: ☐ Wig ☐ Counseling (Patient and/or Family)

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

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 and up

Number Living in Household: _____

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

OFFICE USE ONLY:

Allocation: _____ Notes: _____