CanHope
Helping Local Cancer Patients

P. O. Box 3694
Aiken, S. C. 29802
Phone: 803-649-5433

INDIVIDUAL ASSISTANCE APPLICATION

- Financial support is available to cancer patients who meet **CanHope** guidelines. Support is limited to assistance with cancer-related prescription medications and equipment, and transportation to treatment facilities.
- Proof of income must show recipient's name and may be verified.
- Assistance begins at application approval. Bills acquired prior to approval will not be paid by **CanHope**.
- Patient information is not shared by **CanHope** without patient's written permission.
- Decision of patient assistance is made by **CanHope**. You may request a review & explanation of decision.

CANCER PATIENT INFORMATION

NAME _____ **AGE**_____

Female **Male** (Circle One) **African American** **Caucasian** (Circle One) **Hispanic** **Other** _____

ADDRESS _____
Street City State Zip Code

Mailing address if different: _____

COUNTY _____ **PHONE # Home** _____ Cell: _____

SOCIAL SECURITY NUMBER _____-_____-_____ **Date of Birth** _____-_____-_____

MEDICARE – Yes___ No___ **MEDICAID** – Yes ___ No ___ **Health Insurance** – Yes ___ No ___

Name of Health Insurance - _____

Other assistance being received? - Yes____ No____ If 'Yes' please list._____

_____

MARITAL STATUS (circle one) Single Married Divorced Widowed

NAME OF SPOUSE /PARENT /GUARDIAN _____

NAME & AGE OF DEPENDENTS _____

LIST ANY OTHER HOUSEHOLD MEMBERS _____

HOUSEHOLD FINANCIAL INFORMATION

List **all** income of **all** household members. **Proof of income is required** through prior year tax return, copy of monthly support income (child support, SSI, Social Security, pension, etc) or two recent pay stubs.

Recipients Name _____ Income Source _____ Monthly Amount $_____

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TREATMENT PLAN INFORMATION

TYPE of CANCER / Yr. Diagnosed_____

PRIMARY TREATMENT PHYSICIAN'S NAME _____

TREATMENT CENTER ADDRESS & PHONE #_____

_____

DESCRIBE SPECIFIC CANCER ASSISTANCE NEEDED, DURATION, COST.

MEDICATIONS - _____

TRANSPORTATION NEEDS - _____

DISTANCE FROM RESIDENCE TO TREATMENT FACILITY _____ **miles round trip.**

MEDICAL EQUIPMENT - _____

OTHER - _____

EXTENUATING CIRCUMSTANCES _____

_____

Please check this box if you will allow CanHope to share your story to help with raising more funds. ☐

Use additional paper if necessary to provide information.
How did you find out about CanHope?

_____

I ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE **DATE**

I ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN'S *PRINTED* NAME & SIGNATURE **DATE**

To be completed by CanHope

DATE APPLICATION RECEIVED _____

DATE APPLICATION REVIEWED_____ REVIEWED BY _____

DATE APPLICATION APPROVED_____ APPROVED BY_____

DATE APPLICANT NOTIFIED _____ NOTIFIED BY_____

ASSISTANCE TO BE PROVIDED_____

NOTES: _____

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