Application # ____________

Office Location
1337 Medical Ridge Road
Clinton, SC 29325
Office: 864-833-3976
Fax: 864-833-3997
Cell: 864-872-5464

Mailing Address
P.O. Box 0006
Clinton, SC 29325

Email:
lccancerassoc@gmail.com

INDIVIDUAL ASSISTANCE APPLICATION

- **Financial support is available to cancer patients who meet the LCCA guidelines. Support is limited to assistance with cancer-related prescription medications and transportation to treatments.**
- **Proof of all household members' income must show recipients' name and may be verified.**
- **Assistance begins at application approval. Billing acquired prior to approval will not be paid by the LCCA.**
- **Patient information is not shared by LCCA without patient's written permission.**
- **Decision of patient assistance is made by the LCCA. You may request a review & explanation of assistance.**

County: ☐ Laurens ☐ Other ____

First Name: ____________________ **Middle Initial:** _________ **Last Name:** ____________________________

Mailing Address: ____

City: ________________________________ **State** _______________________ **ZIP** _______________

Home Phone (____) _______________ **Cell Phone** (_____) _____________ **Email** ______________________________

Spouse/Caregiver/Significant Other: ____

Date of Birth: ________/________/________ **Age** ___________ **Sex:** ☐ Male ☐ Female

Date: _______________________ **Height:** ___________________ **Weight:** __________________

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

Family/Friend Name (not living with you) ___________________________ **Relationship:** ____________________

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

Oncologist's (Cancer Dr.) Name: ________________________________ **Phone Number:** ____________________

Cancer Diagnosis 1: ____ (date diagnosed: ____________________)

Cancer Diagnosis 2: ____ (date diagnosed: ____________________)

Treatment: Chemo *(start date)*: ______________________ **Radiation *(start date)*** ____________________________

<u>Cancer Medication</u> Client is Taking ____

Your <u>actual out of pocket cost</u> each month for cancer medications only $_____________________(paid receipt required)

Are you a Smoker? ☐ **YES** ☐ **NO** **If yes, how long?** ____________ **If quit, for how long?** _______________

Veteran in Household? ☐ **YES** ☐ **NO** **How did you hear about us?** ____________________________

Are you a Hospice patient? ☐ **YES** ☐ **NO** **If yes, who is your nurse or social worker?** ____________________

What pharmacy do you currently use? **Phone Number**

What medications are you currently taking?____

____

What assistance needs to be provided?

____

____

____

Are there any extenuating circumstances occurring in your family, which limits your ability to meet all your current needs? (i.e. household family member with a chronic illness)____________________________

____

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

Estimated Total Household Income:	☐ $0-22,340	☐ $22,341-30,260	☐ $30,261-38,180
	☐ $38,181-46,100	☐ $46,101-54,020	☐ $54,021 and up

Number in Household: ____________ **Major Medical Insurance** ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ None

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

I affirm that the above information is true and complete to the best of my knowledge. I also understand that any and all information may be verified independently at the sole discretion of the Laurens County Cancer Association(LCCA), and I expressly give my permission for such inquiry and verification. If benefits are extended to me (the prospective client), LCCA has the right to terminate any or all assistance to me (the prospective client) upon periodic review of my case. I further understand that this aid is limited depending on the availability of funds. The LCCA elects in its sole discretion to provide financial assistance to me (the prospective client), I further understand that the LCCA is neither recommending nor discouraging any particular treatment, and that the LCCA will be held harmless from any claim arising from treatment provided or withheld, and that no promise or inducement of any kind has been made by the LCCA.

I herby authorize the release of my medical records and medical information concerning my cancer diagnosis, its treatment and the diagnosis and treatment of my cancer-related conditions by my medical providers, including my physicians and my pharmacies, to LCCA so that the LCCA may confirm my diagnosis and treatment and receive updates of my conditions and treatments with such authorization to be effective until the earlier of (1) the revocation of this authorization by me or (2) the date LCCA terminates its relationship to me.

__________________________________ ____________________________
Signature Date

OFFICE USE ONLY:

Allocation: __________________________________ Notes: ________________________________