Jamestown Families Cancer Care

Application for Financial Assistance

The example Doctor's letter that is found on our website stating you are in current treatment MUST accompany this application.

please use the TAB button when filling out

Name_____ Date of Birth_____

Address_____
(Street) (City) (Zip Code)

Phone_____ Home **Check primary** Cell _____

E-mail_____

Number of children in household under the age of 19. _____

School District_____

Place of Employment_____

Emergency Contact _____
(Name) (Phone Number)

Diagnosis_____

Physician/clinic_____

Card(s) will be DELIVERED to address above

Assistance can **only** be used for:
Transportation/ Fuel, Grocery's/Food, Co-pays for treatment medicines, or **incidentals pertaining to specific need**
(Recipients will need to submit travel log to receive fuel reimbursement, all other aid will be supported by information from above)

Please indicate where aid is needed **Food** **Jamestown Market** **Transportation reimbursment card** **Pharmacy** **IHS**

Return application & letter to:
Jamestown Families Cancer Care
P. O. Box 35
Jamestown, OH 45335

Contact numbers:
C: 937-542-9810 – Chairperson, Connie Hansen
C: 937-622-3360 – Co-Chairperson, Brian Coffman

Please address all question(s) to: Contact numbers or email address

Please visit us at our Website: www.jamestownfamiliescancercare.org

Or check out our Facebook Page: Jamestown Families Cancer Care

Or E-mail us at: jamestownfamiliescc@gmail.com

Note: Once this application is approved and you begin receiving assistance, for your application to remain active, every four (4) months we will require our Doctor's letter from your physician/clinic, that you still are receiving treatment. Failure to provide these updates when required will result in termination of assistance.

----------our use below this line----------

Date application received _____ Initials_____ Date application approved_____ Initials_____

Medical letter with application

Date: _____

To: Jamestown Families Cancer Care
P.O. Box 35
Jamestown, OH 45335

Dear Sir/Madam:

I, _____, hereby confirm that _____ is
(Doctor's Name) (Patient's Name)
going through active cancer treatments, **(Active treatment is defined as being seen at a minimum of once per month).** He/She is suffering from _____.
Type of treatment.

□ Patient is being seen at least once per month by a Cancer Specialist
(if box is not checked patient will not qualify for assistance)

Please indicate the type of treatment the patient is receiving.

□ Surgery, ending _____

□ Chemotherapy, ending _____

□ Radiation, ending _____

□ Immunotherapy, ending _____

□ Hormone Therapy, ending _____

□ Bone Marrow Transplant, ending _____

□ Photodynamic Therapy, ending _____

□ Targeted Drug Therapy, ending _____

□ Cryoablation, ending _____

□ Radiofrequency Ablation, ending _____

□ Clinical Trial, ending_____

Sincerely,

_____
Doctor's Signature

Doctor's Printed Name: _____

Name and Address of Facility (Stamp is accepted)

This information is to help provide financial assistance for the above patient.

_____
Patient's signature for consent of release of information