

Cancer Association of Anderson

215 E. Calhoun Street

Anderson, SC 29621

Phone: 864-222-3500 Fax: 864-222-3502

APPLICATION FOR SERVICE

Date _____ Soc. Sec. # _____ Phone _____

Patient's Name _____ E-mail _____

Address _____ City-Zip _____ County _____

Birth date _____ Age _____ Sex _____ Race _____ Marital Status _____ # in Family _____

Caregiver's Name _____ Relationship _____

Address _____ Phone _____

OTHER PEOPLE WHO MAY CONTACT CAA ON BEHALF OF PATIENT: _____

Referred by _____ Patient's cancer doctor _____

Type of cancer _____ Current treatment _____

Date of diagnosis or most recent reoccurrence _____

Insurance Coverage: Medicare _____ Medicaid _____ AnMed Infusion Center _____ Other _____

Private insurance (name of company or plan) _____

Other _____

Type of service(s) needed: 1) _____

2) _____

3) _____

If you are seeking financial assistance, you MUST answer these questions:

Source of support (Patient) _____ Total monthly income \$ _____

Source of support (Spouse) _____ Total monthly income \$ _____

STAFF USE ONLY

This patient was informed of the following services:

____ Financial Aid ____ Oncology Rehab ____ Hat and Wig Closet ____ Support Groups

This patient was given a: Prayer shawl ____ Yes ____ No Lydia Bag # _____

*Faxed to Free Clinic: _____

Date

*Faxed "Doctor's Form": _____

Date

Cancer Association of Anderson
215 E. Calhoun Street
Anderson, SC 29621
Phone: 864-222-3500 Fax: 864-222-3502

DOCTOR'S FORM

_____ is receiving services provided by the Cancer Association of Anderson.

THE PATIENT/GUARDIAN, BY SIGNING BELOW, HEREBY GIVES PERMISSION TO HER/HER PHYSICIAN TO RELEASE THE HEALTH INFORMATION LISTED BELOW:

Patient or Guardian's Signature

Address

City, State Zip

Date

Phone

THE PHYSICIAN SHOULD COMPLETE THE FOLLOWING AND MAIL OR FAX TO THE ABOVE ADDRESS or GIVE IT TO THE PATIENT TO RETURN TO CAA

Patient _____

Diagnosis _____

This patient has cancer. YES NO

CANCER RELATED DRUGS ONLY _____

Comments _____

Physician's Signature

Address

Supporting Staff (contact nurse or office assistant): _____

Date

Phone