

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 Health Infusion Center _____

Private insurance (name 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 _____

Present monthly expenses (amount): House _____ Rent _____ Car _____ Utilities _____

List unusual expenses or money you owe _____

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 # _____

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AUTHORIZATION TO RELEASE & OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME (Please print) _____

I understand that in order to assist me or my family, the Cancer Association of Anderson will need to share information about my medical, financial and personal situation or request information about my medical, financial and personal situation from various individuals, institutions and/or agencies. Communication may be verbal, written or transmitted electronically (i.e. by e-mail or fax) to such entities as:

- My attending physician or physicians
 - My pharmacist or a pharmacist used by CAA to provide medicine for me
 - Medical equipment vendors
 - Home health care providers
 - Hospice staff
 - Hospital professionals and staff
 - Support group leaders and members
 - Cancer survivors who serve as peer counselors
 - Volunteers for CAA
 - Other non-profit organizations that provide assistance
 - Churches that provide assistance
 - Governmental agencies that provide assistance
 - Others not specifically listed that may be enlisted to assist me.
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- I hereby give my permission for the CAA to share information I have provided, in writing and/or verbally in interviews, to the above listed individuals, institutions and/or agencies as needed to assist me and my family during my current illness and in survivorship.

 - I hereby give permission for the CAA to seek additional information from the above listed individuals, institutions or agencies as needed to assist me and my family during my current illness and in survivorship.

 - I, on behalf of myself or any other person who may have an interest in the matter, hereby release CAA and the institution, agency or caseworker supplying confidential information from all legal responsibility that may arise from the act I have authorized above.

Signature of Adult Patient: _____

Signature of Adult Applicant on Behalf of Patient: _____

Signature of CAA Representative: _____

Date _____

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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