Assistance in Healthcare, Inc.
Monthly Request for Assistance

~~~All information must be complete for application to be processed~~~
~~Please attach a copy of the bill you need assistance with~~

~~Only patients currently undergoing cancer treatment will be considered for assistance~~

Patient name: ____

Address: ____

____

Home phone: ______________________ **Work phone:** ______________________

Requesting assistance for: (List non-medical expenses only) ______________________

____

Amount of request: ($) ____

I authorize a representative of Assistance In Health Care, Inc to contact my physician

______________________ **at** ______________________ **for verification of**

my diagnosis &treatment dates. My physician's phone number is ______________________

____ ______________________
Signature **Date**

This section to be completed by: **Social Worker** ☐ **Nurse** ☐ **Physician** ☐ **Medical Ass't**

Type of cancer: ______________________________________ **Stage:** ______________

Treatment Dates: ______________________ **Under Active Treatment:** ☐**Yes** ☐**No**

Treatment Type: ☐ **Chemo** ☐ **Radiation** ☐ **Surgery** ☐ **Transplant** ☐ **Follow up only**

Treatment Plan: ____

Signature: ______________________________________ **Phone:** ______________

Print Name/Title: ____

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