

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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**Application due by month end – for consideration in the following month**