

**ASSISTANCE IN HEALTH CARE, INC.
REQUEST FOR ASSISTANCE**

~~~All information must be complete for application to be processed~~~

~~Please attach a copy of the bill with which you need assistance~~

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

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**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 and treatment dates. My physician's phone number is** \_\_\_\_\_.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

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**FOR OFFICE USE ONLY:**

**PREVIOUS ASSISTANCE** \_\_\_\_\_ **AMOUNT APPROVED** \_\_\_\_\_

**CHECK TO** \_\_\_\_\_ **DATE** \_\_\_\_\_

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