



Assistance In Health Care, Inc.

Dear Friend,

Assistance in Health Care, Inc. was established in 1993 by a group of volunteers at Cancer Treatment Centers of America in Tulsa, Oklahoma solely for the purpose of raising funds to support cancer patients and their families. The support now extends to the Tulsa area: we receive referrals from area hospitals and community agencies. Assistance in Health Care is a 501 (c) (3) not-for-profit organization which receives no state or federal funding, relying on the support of individual donors, and gifts are tax-deductible.

Patients undergoing cancer treatment in the Tulsa area can complete the attached written application requesting assistance. Requests are presented to the Assistance in Health Care Board for review and approval on a monthly basis. The organization provides financial support for expenses other than hospital, physician, medication and supplements, hotel accommodations and airline charges. Funds have been provided for rent, utilities, car payments and various other emergency needs. The organization meets every second week of the month to distribute funds to those who meet criteria. All applications are due by the first Friday of each month. Applications must be filled out monthly in order to be considered for assistance.

Our goal is to bring hope, dignity and relief to cancer patients and their families.

Sincerely,

Debbie Baugh
President

TH:lw

Application for Assistance

Date: _____

Patient's Name: _____ Age: _____

Spouse's Name: _____ Age: _____

Date of Birth: _____

Phone Numbers: _____

Address: _____

City, State & Zip: _____

Diagnosis & Condition of Patient: _____

Ages of Dependent Children: _____ # Living in Household: _____

Others financially dependent on applicant: _____

	Patient	Spouse	Other
Employer	_____	_____	_____
Occupation	_____	_____	_____
Sources of Income:			
Alimony	_____	_____	_____
Child Support	_____	_____	_____
Interest Income	_____	_____	_____
Military Benefits	_____	_____	_____
Net Wages (After Taxes)	_____	_____	_____
Rental Income	_____	_____	_____
Retirement Benefits	_____	_____	_____
Room/Board	_____	_____	_____
Savings/Investment Income	_____	_____	_____
Sick pay	_____	_____	_____
Social Security Income	_____	_____	_____
Trust Funds	_____	_____	_____
Unemployment	_____	_____	_____
Welfare/Food Vouchers	_____	_____	_____
Other: _____	_____	_____	_____

Total:

Assistance In Health Care, Inc.

P.O. Box 700392

Tulsa, OK 74170-0392

Ph: (918) 286-5110 Fax: (918) 249-7511

Application Continued

Home Related Monthly Expenses:

Rent _____

Mortgage _____

Utilities (Combined) _____

•Includes electric, gas, phone, cell phone, sewage, trash, television, internet

Monthly Insurance Premium

Home _____

Vehicle _____

Food/Groceries _____

Car Payment (1) _____

Car Payment (2) _____

Gasoline _____

Other _____

•Please list separately and itemize

•Do not include medical expenses

•Include credit card names and minimum balance

Total: _____

Monthly Medical Expenses:

_____ Prescription Copays for Patient

_____ Medical Copays for Patient

_____ Monthly Medical Insurance Premiums

Grand Total:

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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~~

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

\_\_\_\_\_

Signature

Date

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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**