



MECKLENBURG COUNTY CANCER ASSOCIATION
P O BOX 383,
SOUTH HILL, VA 23970
www.mecklenburgcancer.com

APPLICATION FOR ASSISTANCE

SECTION A – GENERAL INFORMATION

Patient's Name _____
(Last) (First) (Middle)

Address _____

(City) (State) (Zip Code)

Patient's Phone # _____

Date of Birth _____ Social Security # _____

Are you currently receiving financial assistance from any other source? _____

Are you a Medicaid Recipient? _____ Do you have Hospital Insurance? _____

Have you applied for assistance with us before? _____, If so, when _____

At this time, what is financial assistance needed for the most:

Transportation _____ Food/Bills _____ Medication _____ Medical Care _____

SECTION B – MEDICAL INFORMATION

Diagnosis _____

Where are you being treated? _____

Doctor's Name and Telephone # _____

Type of Treatment(s) Prescribed: Chemo _____ Radiation _____ Surgery _____
Other _____

I hereby certify the above questions have been answered truthfully and to the best of my knowledge. By signing below, I hereby request and authorize the doctor listed in Section B of this form, and all associated medical care providers, to furnish any officer of the Mecklenburg County Cancer Association (MCCA), any and all records and medical information relating to my diagnosis and treatment of cancer. As the person signing this consent, I understand that I am giving my permission to the MCCA, the disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. All information disclosed to MCCA will remain confidential and used for verification purposes only.

Signature _____ Date _____

(Please use reverse side for additional remarks.)

THE MCCA IS AN EQUAL OPPORTUNITY PROVIDER. ALL APPLICATIONS ARE REVIEWED
WITHOUT REGARD TO RACE, SEX, AGE, NATIONAL ORIGIN OR DISABILITY.
MCCA IS AN IRS APPROVED 501(c)(3) NON-PROFIT CHARITABLE ORGANIZATION.