CANCER CONNECTION RESOURCE CENTER APPLICAITON

APPLICANT NAME & CONTACT INFORMATION

First Name: ____________________ Last Name: ____________________

Date of Birth: ______/______/______ (month/day/year)

Address: ____

City: ______________ State:______________ Zip Code: ______________

Home Phone: (   )______________ Cell Phone: ( )______________

Email Address: ____

ETHNIC ORIGIN (Optional)

Caucasian   African-American   Hispanic/Latin

Other

Monthly Income: ____

DIAGNOSIS

Date of Diagnosis: ____

Type of Cancer: -

Current Doctor/Oncologist: ____

REQUEST FOR ASSISTANCE: Financial assistance; Housecleaning; Transportation
Please briefly state your need at this time: _____

_____

_____

_____

CONSENT INFORMATION

I **give** Cancer Connection Resource Center (CCRS) and my doctor(s) permission to:

- Verify my information to make sure it is true and complete.
- Share my information with authorized representatives of the Cancer Connection Resource Center.
- Contact me by telephone or email about Cancer Connection Resource Center, or other programs or services that might interest me.

I **understand** that:

- Cancer Connection Resource Center will only use my information for intake purposes and to determine my eligibility for and the amount of financial assistance and/or other services I may be provided with.
- I may cancel my permission to use my information and withdraw from the Program at any time.
- Cancer Connection Resource Center may change or stop any portion of the Program at any time for any reason with or without notice.
- Cancer Connection Resource Center is not a medical provider and is not in any way liable for the success or failure of any treatment program that I may elect to undertake or participate in.

I hereby **certify that the above statements are true** and correct to the best of my knowledge. I understand that a false statement may disqualify me for assistance.

_____ _____

Signature of Applicant or Authorized Representative Date

CANCER CONNECTION RESOURCE CENTER
APPLICATION CHECKLIST

Please submit the following documents along with your application:

- □ Physician Verification Form signed by your **Health Care Provider(i.e. social worker; financial counselor; Registered Nurse; Oncologist)**
- □ Current Proof of Monthly Income.
- □ Proof of Residency (Copy of Driver's License or Identification Card).
- □ Completed Application indicating financial or other needs.

Please make sure that:

- □ You have filled out the **Application** completely before submitting;
- □ You are in contact with your doctor to make sure he/she has completed the **Physician Verification Form** and has returned it to us;
- □ You make a photocopy of your completed **Application** for your records;
- □ You sign and date the **Application**.

PLEASE NOTE: Your application cannot be processed until we have received all of the required documents. Additional documents to support your request such as copies of medical bills, utility bills or leases may be requested. Please allow 1-3 weeks for applications to be processed once all required documents have been received.

Completed applications should be returned by fax to:

Cancer Connection Resource Center
P.O. Box 6906
Largo, Md. 20792
Phone: 240-463-9617
Fax: 888-284-0728
www.ccrc4me.org

THANK YOU FOR CONTACTING CANCER CONNECTION RESOURCE CENTER
WE LOOK FORWARD TO WORKING WITH YOU.


CANCER CONNECTION
RESOURCE CENTER

CANCER CONNECTION RESOURCE CENTER
PHYSICIAN VERIFICATION FORM

Dear Physician,

Your patient has applied for enrollment in the Cancer Connection Resource Center, which provides financial support and other assistance to patients with a diagnosis of Cancer and in active treatment up to one (1) year after initial diagnosis.

In order to complete the enrollment process, we must verify the following information with you as the prescribing and/or treating physician. Please return the form back to the following fax number provided: (888) 284-0728 Please contact us with any questions that you may have about this form.

PRESCRIBING PHYSICIAN:

First Name: _____ Last Name: _____

NPI #_____

Business Address: _____

City: _____ State:_____ Zip Code: _____

Phone: ( )_____ Fax: ( )_____ Email: _____

Contact Person: _____

Title: _____

Phone (if different from above) ( )_____

Health care provider signature: _____