Henry County Cancer Services

New Applicant_____
Renewing Applicant_____

Application For Assistance

Step 2

Applicant Name: _____

Attending Physician's Name **(please Print)**: _____

Attending Physician's Phone #: _____

Attending Physician To Complete The Following

I hereby confirm the above named applicant has a cancer diagnosis AND is currently receiving active treatment for cancer.

_____ _____

Attending Physician Signature Date

*****Attending Physician Must Sign In Order For Application To Be Processed*****

Completed Form May Be Submitted Via The Following:
Email: cancer.services@gmail.com Mail: P.O. Box 3417, McDonough, GA, 30253

HCCS Use Only

(Do Not Complete)

Date Completed Application Received: _____

Information Verification Completed By: _____

Application Approved By: _____ Date of Approval: _____

Waiting List: _____ Date Placed on Waiting List: _____

Assistance To Be Provided:

- Medication (reimbursement)
- Medical Bills (reimbursement)
- Mileage (reimbursement)
- Wig/Turbans/Prosthetic Devices (reimbursement)
- Other (specify): _____