

New Applicant  
 Renewing Applicant

### Assistance Application

Henry County Cancer Services, Inc.  
P.O. Box 3417  
McDonough, GA 30252  
770-288-6510 (Phone)  
770-288-6509 (Fax)

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Street Address: \_\_\_\_\_ Phone 1: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Type of Cancer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone \_\_\_\_\_

Family Member/Friend Contact: \_\_\_\_\_ Phone \_\_\_\_\_

**Type of Assistance Needed (please indicate all that apply):**

Reimbursement for:

- Medical Bills
- Transportation
- Wigs/Turbans
- Other (Please specify): \_\_\_\_\_
- Medications

Do you need assistance with food?

- Yes
- No

Are you covered by (please indicate all that apply):

(This information is for referral purposes only and will NOT affect program eligibility)

- Private insurance
- Medicaid
- Medicare
- Other (please specify): \_\_\_\_\_

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Applicant Name: \_\_\_\_\_

Attending Physician Name (please print): \_\_\_\_\_

Phone # \_\_\_\_\_

**Physician to complete the following:**

I confirm that the above named applicant

- Has a cancer diagnosis AND
- Is currently receiving active treatment for cancer:

\*\*Physician Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*Applications MUST be signed by an attending physician:**

**HCCS USE ONLY:**

Date Application Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Verification of Information by: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date Approved: \_\_\_\_/\_\_\_\_/\_\_\_\_

Waiting List: \_\_\_\_\_ Date Placed on Waiting List: \_\_\_\_/\_\_\_\_/\_\_\_\_

Assistance to be provided:

\_\_\_\_\_ Medications:

\_\_\_\_\_ Medical Bills

\_\_\_\_\_ Transportation

\_\_\_\_\_ Wig/turbans/prosthetic devices

\_\_\_\_\_ Other: (Specify) \_\_\_\_\_

\_\_\_\_\_ Angel Food