Rock County Cancer Coalition Application

Name _____ Phone (____) _____

Address_____ Age_____ Birth Date _____

City _____ Zip Code_____

Married____ Single___ Children Yes No Ages_____

Oncologist_____ Phone (____) _____

Clinic/Hospital

Type of cancer _____

Should RCCC need to contact you for any reason, please provide name and phone number of additional contact to act on your behalf should we not be able to reach you directly:

Name

Additional Contact Person Phone (____) _____

How did you hear about Rock County Cancer Coalition?
_____Case Manager/Cancer Navigator (name and contact #)

_____Other_____

I verify that I currently am living **FULL TIME** in Rock County, Wisconsin. That I am actively seeking treatment in a fact based, clinically proven cancer treatment and receiving treatment at least every 3 months. I am requesting assistance from Rock County Cancer Coalition. All information is accurate and up to date.

_____ Date: _____
(Applicant's signature)

Application are reviewed and acted upon at the end of each month.

If any information on this application is not accurate. Application will be rejected and no benefits from RCCC will be awarded!
Application are kept on file at RCCC for a minimum of one year.

Rock County Cancer Coalition Application

Name

Request for Assistance:

Required: You must include a current copy of each bill/expense that you are asking assistance with:

Not covered by RCCC: Property Taxes, Medical bills, Spectrum and Charter bills.

Will pay up to $1125.00.
Will pay in even dollar amounts.
Checks mailed to client.

_____ **Rent/Mortgage** payments. Even dollar amount and a copy of current lease or mortgage

Company name: _____
Amount Requested: _____

_____ **Utilities water, electric, sewer.** Even dollar amount and a copy of current bill.
Company name: _____
Amount Requested: _____

_____ **Phone, cable, internet bill.** Even amount and a copy of current bill.
Company name: _____
Amount Requested: _____

Insurance (Car or Health). Even amount and a copy of current bill.
Company name
Amount Requested

Car payment. Even amount and a copy of current bill.
Company name
Amount Requested

Please make sure that the total amount of assistance does not exceed $1125.00 if requesting more than one bill to be paid.

****in order to make sure your application is accepted/processed in a timely basis, please make sure that you have **CLEARLY** expressed your requested assistance and you have provided the necessary back-up for requested assistance

Application are reviewed and acted upon at the end of each month.