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/Phone _____

_____

Additional Contact Person Name/Phone _____

_____

How did you hear about Rock County Cancer Coalition? _____

Case Manager/Cancer Navigator (state name and contact #) _____

_____

Medical professional (state medical facility) _____

_____

Other _____

_____

Is this the first time you have applied for assistance from RCCC

___ Yes

___ No; if no when was the last time you applied for or received assisted from RCCC

Date of last application _____ or Date of last assistance _____

******Reminder you MUST be CURRENTLY in an active treatment of cancer and have not been funded by RCCC within the last 12 months*******

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

_____ Date: _____

(Applicant's signature)

Applications are reviewed and acted upon twice a month