Rock County Cancer Coalition Application

Name _____ Phone (_____) _____

Address_____ City _____ Zip _____

Email_____ Birth Date _____Age_____

Race: (circle one) Asian Black/African American Hispanic/Latino Multi-Racial Native American White/Caucasian
Other:_____

Gender: (circle one) Female Male Transgender Non-Conforming

Oncologist_____Type of cancer _____

Clinic/Hospital _____Phone (_____) _____

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 _____

How did you hear about the Rock County Cancer Coalition _____

Is this the first time you have applied for assistance from RCCC? (Circle one) YES NO

Since you started receiving cancer treatments, would you say that the financial obligations associated with your treatments have: **(circle one)** **a**. Not caused you any stress **b.** Caused you slightly increased stress **c.** Caused you significantly increased stress

I verify that I am currently living in Rock County, WI **full time**, that I am in active treatment for cancer, and I have not received financial assistance through RCCC in the last 12 months

_____ Date: _____
(Applicant's signature)

Applications are reviewed and processed within 30 days of RCCC receiving the application. You should continue to pay your bills and RCCC is not liable for any late payments.