Monroe County Assistance Fund for Cancer Patients

Monroe County Health Council, A participating agency in Monroe County United Way

PATIENT INFORMATION

Name:_____
First Middle Last

Address:_____
Mailing/Street Address

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Date of Birth:_____ Sex:_____

Do you have insurance?_____ Private:_____ TN Care:_____

DIAGNOSIS (Type of Cancer):_____

TYPE OF RECENT/CURRENT TREATMENTS(S) (Circle all that apply):

Chemotherapy Radiation Surgery

Date(s) of the above treatment(s) beginning and ending dates of chemotherapy and/or radiation.

_____

SPECIFIC ASSISTANCE REQUESTED:

Transportation: To_____, From_____
(Town or Hospital) (Where you Live)

Mileage (round-trip) if known_____miles. Number of trips_____

OTHER NEEDS (Please be specific):_____

In my opinion, this patient is in need of economic assistance as requested above:

_____ _____
Physician or Nurse Signature (specify if other) Date

_____ _____
Please Print Above Name Agency or Office & Phone Number

Authorization of Release of Medical Information: I hereby give my consent to release the above information in this form to the Executive Director of the Monroe County Health Council, for a period of 90 days, for the purpose of application verification.

_____
Signature of Client and Date

Please return form to:
Monroe County Health Council, Monroe County Cancer Fund
P.O. Box 1119, Madisonville, TN 37354
Phone/Fax: (423) 545-3015
www.monroehealth.org