1507 E. SPRAGUE
SPOKANE, WA 99202
(509) 456-0446
Fax: (509) 456-0459
www.cancerpatientcare.org

OFFICE USE ONLY – PATIENT NO:
ACTIVE: _____
INACTIVE: _____
MAMMOGRAM: _____

Cancer Patient Care provides services to Eastern Washington and Northern Idaho

DATE:	FIRST NAME: M.I. LAST NAME:	
DATE OF BIRTH:	ADDRESS:	
TELEPHONE:	CITY: STATE: ZIP:	
MALE: ___ FEMALE: ___	SOCIAL SECURITY #:	EMPLOYER:

CONTACT PERSON: ADDRESS: CITY, STATE, ZIP: PHONE: RELATIONSHIP:

PHYSICIAN:	DIAGNOSIS:
CARETAKER:	REFERRED BY:

HOUSEHOLD GROSS MONTHLY INCOME:
Self: $ _____/month
Spouse: $ _____/month
Other: $ _____/month
Food Stamps: $_____/month

LIQUID ASSESTS:
(Savings, Stocks, Bonds, Annuities)
$_____

RENT or MORTGAGE (circle one):
Payment: $_____/month

OF PEOPLE IN HOUSEHOLD:
_____Adults
_____Children (under age 18)

HEALTH INSURANCE COMPANY:

OTHER AGENCY ASSISTANCE:

SERVICES REQUESTED:

____ Service Referrals
* ____ Emergency Funds
___ Heat/Lights
___ Water
___ Grocery
* ____ Food Supplement
___ Ensure Plus
___ Boost
___ Boost Plus
___ Boost Pudding
* ____ Mammogram
* ____ Prescriptions
____ Non-Prescription Medical Supplies
* ____ Transportation
____ Wig Closet
* ____ Lifeline
____ Equipment Loan

* **Income Qualified Services**

COMMENTS:

AUTHORIZATIONS:

SERVICE ELIGIBILITY FORM

In order to qualify for services through Cancer Patient Care an individual must be undergoing treatment (chemotherapy and/or radiation) or have had cancer-related surgery within the last **six months.**

We will provide services while the cancer patient is **undergoing treatment**, and for an **additional six months following cessation of treatment** if needed.

If the patient has had cancer-related surgery, we will provide services for **six months** following surgery.

SERVICE ELIGIBILITY VERIFICATION:

Diagnosis (cancer site):_____

Date of diagnosis:_____

Date treatment began (or will begin):_____

Treatments you are currently undergoing: (check all that are applicable)

_____Radiation

_____ Chemotherapy

_____Surgery

When did/will treatments end?_____

In order for Cancer Patient Care to provide services we must confirm diagnosis and treatment status with your physician. Please provide the following information.

Name of Physician(s):

a) Primary care provider:_____

Address:_____

Phone Number:_____

b) Oncologist:_____

Address:_____

Phone Number:_____

Applicants Statement of Understanding

I have read and understand the above and declare the information furnished by me is true and complete to the best of my knowledge. I hereby authorize CANCER PATIENT CARE to contact my physician and obtain appropriate medical information regarding my care. In addition, I consent to the exchange of information between CANCER PATIENT CARE and other community agencies to provide needed services.

_____
Applicant/Responsible Party

_____
Date

Cancer Patient Care is a United Way Agency serving the needs of low income cancer patients and their families. Cancer Patient Care does not discriminate against any person because of their race, creed, religion, gender, or age.

RELEASE OF LIABILITY

Whereas, **CANCER PATIENT CARE**, a Washington Non-Profit Corporation, has, as part of its community care-giving function, made available to the undersigned certain hospital rehabilitative equipment including, without limitation, a hospital bed, wheelchair, hospital appliances and/or other similar devices, hereinafter referred to as "medical equipment" at no charge to the undersigned; and

Whereas, in consideration for the use of such equipment free of charge, the undersigned does hereby agree to release any liability connected with such use which may be found to exist between **CANCER PATIENT CARE**, its officers, directors, employees or agents, and the undersigned, his/her agents, executors, successors, personal representatives or assigns;

Now therefore, for and in consideration of the recitation set forth above, and the terms and provisions herein contained, the parties do hereby covenant, agree and promise as follows:

In consideration of the use of the hospital equipment free of charges granted hereunder, the undersigned, for and on behalf of themselves, their marital community, their successors, agents, servants, assigns, personal representatives, heirs or others who might succeed to the interest of the undersigned, hereby and forever release **CANCER PATIENT CARE**, it's agents, employees, directors, officers, and members, from all debts, claims, demands, actions or causes of action whatsoever which may accrue as a result of the use of the said medical equipment. The undersigned, for and on behalf of themselves and the others mentioned hereinabove, further agree to protect, indemnify and hold **CANCER PATIENT CARE** harmless against and in respect of any liability, direct or indirect, arising out of any injury or damage occurring or alleged to have occurred after the date of possession or within or upon any premise wherein use of this medical equipment is contemplated.

This is intended to be a release of all claims, known or unknown, contingent, liquidated, now known or hereafter accruing, and shall act to prevent the undersigned, his or her heirs, successors, agents, assigns, personal representatives or heirs from bringing any action whatsoever against **CANCER PATIENT CARE**, its officers, agents, employees, directors or members, which might arise out of the use of this medical equipment.

THIS IS A BINDING LEGAL AGREEMENT WHICH SUBSTANTIALLY LIMITS YOUR LEGAL RIGHTS. YOU ARE URGED TO CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT. YOUR SIGNATURE HEREON ACTS TO WAIVE ALL CLAIMS WHICH MIGHT BE RAISED AGAINST CANCER PATIENT CARE FOR THE USE OF THE HOSPITAL EQUIPMENT DESCRIBED ABOVE.

_____
Signature

_____
Date

Piece(s) of hospital equipment released:	**Equipment #:**	**Date Recd:**	**Returned:**

Supplies Received:	**Date Recd:**	**Returned:**

Statistical Analysis

As part of our ongoing need for grants and funding, it is frequently necessary that we provide statistical information to our funding sources.

For this purpose, we would like to ask that you provide us with the following information. Please understand however, that in providing this information, complete confidentiality will be maintained.

1) Are you a Spokane County or City resident? (circle one)

County City Other (please specify):_____

2) Are you a single parent supporting minor children? (circle one)

Yes No

3) What is your ethnic background? (check one)

White / Caucasian	___	Native American	___
Hispanic / Spanish	___	Asian	___
African American	___	Other	___

4) Female ___ Male ___

5) Age ___

6) How many people are currently residing in your household? _____

We appreciate your support! Thank you for your time.

The Following To Be Completed by Social Services Department:

Household Income

Household Size:	1	2	3	4	5	6	7	8
30% MFI (extremely low)	9,800	11,200	12,600	14,000	15,100	16,200	17,350	18,450
50% MFI (very low)	16,300	18,650	20,950	23,300	25,150	27,050	28,900	30,750
80% MFI (low)	26,100	29,800	33,550	37,300	40,250	43,250	46,250	49,200

(for larger households, see previously established format)
MFI = Median Family Income for the Spokane Area
Income limits are changed periodically by the US Department of Housing and Urban Development (HUD)