Washington Regional

J.B. Hunt Transport Services
Cancer Support Home

CANCER HELP FUND
APPLICATION

Date:_____

Patient's Name:_____ Date of Birth _____ Age _____

Address:_____City/State/Zip_____

Home Number:_____ Cell Phone _____ Email _____

County _____ Are you an Arkansas resident? _____ How long? _____

Please circle ethnicity:

Arab American, African American, Asian/Pacific American, Caucasian, Indian, Latino, Native American, other

What type of assistance requested? _____

Please include a copy of a bill(s) for which you are requesting assistance

Financial Information

Monthly Household Income $_____ # in Household _____ # of Dependents _____

Current Employment: Full Time __ Part Time __ Not Working __ Retired __ Employer _____

Spouse Employment: Full Time __ Part Time __ Not Working __ Retired __ Employer _____

Insurance Information

Do you have health insurance? ____ Carrier? _____ Deductible $_____

Do you have a prescription drug plan?_____

Do you have Medicare/Medicaid? _____

Are you currently receiving assistance from another organization? _____ Please List _____

Patient Signature _____ Date _____

To be completed by the patient's prescribing healthcare provider; *please note signatures must be original*

Patient Diagnosis _____

Date of Diagnosis _____Is Patient in Active Treatment or Ongoing Follow-Up? _____

Health Care Provider Name _____ Hospital/Clinic _____

Phone _____Healthcare Provider License # _____

Healthcare Provider Signature _____ Date _____

Allow 2 weeks for your application to be processed and/or bill to be paid.

Washington Regional Cancer Support Home
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Fayetteville, AR 72703
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Fax: 479-404-2161