

 **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 utility/mortgage that you are requesting assistance

If prescription assistance, please list preferred pharmacy _____

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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