



Washington Regional
J.B. Hunt Transport Services
Cancer Support Home

CANCER HELP FUND APPLICATION 2026

Date:
Patient's Name: Date of Birth Age
Address: City/State/Zip
Phone Number: Email
County Are you an Arkansas resident? How long?

Ethnicity - please circle all that apply (this information collected for grant reporting purposes only)
Arab American, African American, Asian, Caucasian, Indian, Latino, Native American, Pacific Islander, Other

Gender:

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 - please check all that apply

Medicare Other supplemental insurance
Medicaid Military
Private Uninsured

Patient Signature Date

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

Box containing fields for Patient Diagnosis, Date of Diagnosis, Health Care Provider Name, Hospital/Clinic, Phone, Healthcare Provider License #, Healthcare Provider Signature, and Date.

Requested assistance may include utilities, rent/mortgage, phone bill, car payment, or other bills

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

Allow 2 weeks for your application to be processed

Priority will be given to first time applicants

Washington Regional Cancer Support Home
488 E. Longview Street
Fayetteville, AR 72703
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