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_____

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*

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 _____

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

Washington Regional Cancer Support Home
488 E. Longview Street
Fayetteville, AR 72703
Phone: 479-404-2162
Fax: 479-404-2161