Cancer Coalition of Ben Hill and Irwin (CCBHI)

APPLICATION FOR ASSISTANCE

ELIGIBILITY REQUIREMENTS FOR FINANCIAL ASSISTANCE

1. The applicant must be a resident of Ben Hill or Irwin for at least six months; or the applicant's family resides in Ben Hill or Irwin, and the applicant is now living in Ben Hill or Irwin while receiving treatment.

2. The applicant must provide written documentation of a cancer diagnosis by the treating physician.

3. The applicant must be receiving medical treatment for the cancer diagnosis that requires travel by the applicant outside of Ben Hill or Irwin **OR** the applicant must be receiving medical treatment for the cancer diagnosis within Ben Hill County.

4. Upon approval by Cancer Coalition, the amount of assistance will be determined.

Applicant's Name: _____Application Date:_____

Mailing Address:_____
Street/P.O. Box City State Zip

Home Phone: _____Length of Time Living in Ben Hill or Irwin County: _____

Date of Birth: ____/____/____Employer: _____

Work Phone:_____ Emergency Contact Person:_____

Phone: _____Mailing Address:_____

Street/P.O. Box City State Zip _____

Treating Physician: _____Phone:_____

Address of Physician:_____
Street/P.O. Box City, State Zip

I Am Receiving Treatment: (circle one) YES NO Scheduled Where?_____

I have attached written documentation from my treating physician on the physician's letterhead stating the type of cancer that has been diagnosed, the treatment prescribed, and stating that the applicant is receiving or scheduled to receive treatment, including the location of treatment.

I hereby consent that the medical records provided may be made a part of my application for assistance to Cancer Coalition of Ben Hill and Irwin (CCBHI). I further consent that my treating physician shall furnish to CCBHI any additional information concerning my health or physical condition requested by CCBHI or its officials. I understand that my application cannot be processed until I have submitted all required documents to the address shown on the top of this application. By signing below, I certify that this request has been made voluntarily, that I have read and understand this application, and that the information given above is accurate to the best of my knowledge.

Applicant's Signature:_____Date: _____

CCBHIC Representative:_____Date: _____

PLEASE ALLOW 4–6 WEEKS FOR PROCESSING AND DISBURSEMENT BY Cancer Coalition of Ben Hill and Irwin.

BE SURE TO KEEP A COPY OF YOUR APPLICATION AND PHYSICIAN'S LETTER.

Return application and letter to cancercoalitionbhic@gmail.com or
drop off at Colony Bank Attn: Kelli Nelms or Dorminy Medical Center Attn: Holley Lee.