***Cancer Assistance Support Team Application to receive Financial Support***

***Cancer Assistance Support Team*** EIN: 45-5428191 3/2021

Please fill out this application as accurately as possible. If information is not accurate, eligibility will be denied.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: Married or Single

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oncologist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (must submit current pay stub)

Spouse’s Income\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (must submit current pay stub)

Number of immediate family members living in household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Who referred you to CAST? If not referred, how did you hear about us?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check any areas of need….*** \_\_\_\_\_ Doctor and/or hospital bills \_\_\_\_\_Mortgage \_\_\_\_\_ Rent

\_\_\_\_\_Cancer related clothing, compression and/or prosthetics items \_\_\_\_\_Utilities \_\_\_\_\_\_ Giant Eagle cards (if qualify)

\_\_\_\_\_Meals on Wheels (if qualified) \_\_\_\_\_Other (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\*\*\*We Do not provide CREDIT CARDS.***

**Please send completed form to:**

**1333 Burd Ave NE, Massillon, OH 44646**

You will be contacted soon after the application is received. Every six months applications must be re-submitted and approved to continue receiving financial support. Items subject to change.

**Financial support is turned down or discontinued when clients …..**

**Do not submit necessary paperwork (i.e., renewal forms)**

**Do not submit appropriate bills or paper (i.e., outdated bills)**

**Submit medical bills not relating to cancer (i.e., dental bills, etc.)**

**Submit other bills that are not for “necessary” living (i.e., cable or internet)**

**Request the discontinuation of services**

**When the client unfortunately passes**

**Thank you.**

**Cancer Assistance Support Team**