Tri-County Cancer Coalition

Patient Travel Assistance Form

Knox, Laurel, Whitley Counties 2017-2018

DATE: _____

Patient Name: _____Date of Birth____/____/____

Address_____Phone#(____)_____

City_____State_____Zip_____

County_____

This program is designed to assist cancer patients experiencing financial hardship while trying to obtain treatment or follow-up appointments.

Please include pathology report or letter from physician to verify cancer diagnosis
Your application will not be considered without documentation to verify diagnosis

Physician Name_____ Phone# (____)_____

Address_____

City_____State_____Zip_____

Cancer Diagnosis_____Date of Diagnosis____/____/____

Travel From: _____To _____

Number of Miles Round Trip: _____Number of Trips per Month:_____

Treatment Center: _____

Contact Name: _____Contact Phone # (____)_____

Return Forms To:
Tri County Cancer Coalition
P.O Box 1331
Corbin, KY 40701

(This section will be completed by the coalition)

Received By: _____Date____/____/____
Forward To: _____Date____/____/____
Approved ____ Denied _____ Date____/____/____
Check Amt._____ Check # _____ Date Issued: ____/____/____
Notes:
_____
_____
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