# Tri-County Cancer Coalition

## Patient Assistance Application

***Knox, Laurel, Whitley Counties 2017-2018***

**Date of Application_____**

Patient Name:_____Date of Birth____/____/____

Address_____Phone#(____)_____

City_____State_____Zip_____

County_____ Gender: Male / Female

Physician Name_____ Phone# (____)_____

Address_____

City_____State_____Zip_____

Cancer Diagnosis_____Date of Diagnosis____/____/____

**What do you need assistance with?**

Please provide a brief description below. If applicable, please send a prescription from the physician for the requested need.

*****You must complete a different application for travel assistance. Please contact your local health department if you need the travel application*****

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***A pathology report or letter from your physician confirming cancer diagnosis is required along with application.***

*Please be aware that additional information may be required for some forms of requested assistance. The coalition only provides assistance for specific needs outlined in its bylaws. Your request will be reviewed and the coalition will determine if your need can be met.*

**Return Form and Required Documentation To: Tri County Cancer Coalition**
**P.O Box 1331**
**Corbin, KY 40702**

***(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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