

Tri-County Cancer Coalition

Patient Travel Assistance Form Knox, Laurel, Whitley Counties 2019-2020

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:	

