



ASSISTANCE PROGRAM

THIS DOCUMENT WILL BE HELD IN STRICT CONFIDENCE
FALSE OR MISLEADING INFORMATION MAY RESULT IN DENIAL OF ASSISTANCE

Name: _____ Social Security No.: _____ Today's Date _____

Date of Birth: _____ Marital Status: Single Married Divorced Widowed

Gender: Male Female Other Are you currently a resident of Logan County? No Yes

Race/Ethnicity: White Black or African American American Indian or Alaska Native
 Asian Hispanic or Latino Native Hawaiian or Other Pacific Islander

Address: _____ City: _____ Zip: _____

Telephone #: _____ May we leave a message here? No Yes

Emergency Contact: _____ Emergency Contact #: _____

List spouse, children, and others who may be living in your home (if applicable):

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Cancer Diagnosis

Type of cancer: _____ Date diagnosed: _____

What are/have been your treatment options: _____

Where have you been treated: _____

Other information relative to your situation: _____

Are you currently receiving any of the following benefits:

Medicare Medicaid SNAP Social Security Disability No

Do you have prescription drug coverage? No Yes, Provider: _____

Are you a parent or guardian applying for the applicant: No Yes - Name: _____

I certify the above information is true and correct and can be verified. I also certify I am currently being treated for or have previously had cancer. I understand that the Logan County Cancer Society will pay up to, but no more, than \$200.00 a month for supplies and \$300.00 in medication for the treatment of cancer and cancer related illness or injuries. I also understand that the Logan County Cancer Society will make a one time payment up to and no more than \$300.00 for a wig, hair piece, or hair extension.

Applicant/Parent/Guardian Signature

Date



Mission: Provide financial assistance to residents of Logan County who have cancer or cancer related illnesses, while promoting education in the detection and treatment of cancer.

We can help you financially with the following:

Cancer-Related Medication: \$300 per month

Cancer-Related Supplies: \$200 per month

Wigs: \$300 annually

Travel: \$750 per month
to appointments for radiation and chemotherapy, as well as visits to an Oncologist. This assistance is provided in a "fuel only" Speedway gas card.

Expenses are not covered for blood draws, lab work or travel to physical therapy appointments, unless your physician writes a letter stating why physical therapy cannot be done in Logan County.

Screenings: In special circumstances.

Emergency Assistance: \$1,000 annually
Food cards, utility bills, cleaning supplies, special clothing needs, etc. may be provided in special circumstances.

Requirements & Procedure

- Client must be a resident of Logan County to apply.
- Once an application is submitted, an appointment is scheduled to provide required documentation: physician diagnosis, prescription, supplies, etc.
- Application is then approved or denied.
- If the client has insurance, insurance must pay before assistance is provided.
- A voucher is issued to the client for assistance. The voucher is valid for 1-3 months, then must be renewed.
- The client takes (or LCCS will fax) the voucher to an approved pharmacy or business.
- Currently, there is no limit on the length of time assistance may be provided.

Other Resources:

Road to Recovery Program –
<https://www.cancer.org/treatment/support-programs-and-services/road-to-recovery.html>

General information - <https://www.cancer.org/treatment.html>