

APPLICATION FOR FINANCIAL ASSISTANCE/CANCER ASSOC. OF SHELBY COUNTY



Section 1: Personal Information:

Full Name	
Date of Birth:	Social Security Number
Street Address (must match your ID):	
City	State/Zip
Mobile Phone	Work:
Best time to call:	
Email:	
Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated	

Addition Contact Information:

Cancer Association of Shelby County Inc. may discuss my application with the additional people below if we can't reach you directly:

1) Full Name	
Phone:	Relationship
2) Full Name:	
Phone:	Relationship

Insurance Information:

Health Insurance:	☐ None	☐ Medicaid	☐ Medicare
	☐ Private	☐ Other	
Insurance provided through:	☐ My Employment	☐ Spouse Employer	
	☐ None	☐ Cancer Insurance	
	☐ Critical illness	☐ Other Ins. Carrier	

Employment Information:

Employment status BEFORE your cancer Diagnosis:			
☐ Full-time	☐ Part-time	☐ On Leave	☐ Self-employed
☐ Retired	☐ Unemployed		
Employment status AFTER your cancer Diagnosis:			
☐ Full-time	☐ Part-time	☐ On Leave	☐ Self-employed
☐ Retired	☐ Unemployed		
Place of Employment			
Date of last Employment			

CANCER ASSOCIATION OFFICE USE ONLY - DO NOT WRITE IN THIS SECTION

Date Received:	Application Approved	Date Approved:
Review Date 1:	Review Date 2:	Review Date 3:

Mailing Address: Cancer Association of Shelby County Inc., P O Box 844 Shelbyville, IN 46176 317-398-0100

Office Location: Cancer Assoc. of Shelby Co. Inc., 2311 S Miller St., Ste 500., Shelbyville, IN 46176

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Section 2: Monthly Household Income and Current Assets		
Total # of People in Household		
# of Wage Earners in Home:		
# of Dependents:		
Monthly Income Sources (after taxes)	Before Diagnosis	After Diagnosis
Your Employment:		\$
Other Employment (Spouse/Partner/Other):		\$
Social Security:		\$
SSI/DDI:		\$
Employer Disability Insurance:		\$
Unemployment Insurance:		\$
Spouse Unemployment Insurance:		\$
Retirement/Pension/401K/IRA/Old Age Pension		\$
Spouse Retirement/Pension etc.		\$
Alimony		\$
Other Investment Income:		\$
Other (list here)		\$
		\$
MONTHLY TOTAL INCOME:		\$
Loss of income due to your Cancer Diagnosis	☐ No	☐ Yes
Are you currently enrolled in any of the following programs?		
1. Low-Income Energy Assistance Program (LEAP)	☐ No	☐ YES
2. Supplemental Nutritional Assistance Program (SNAP)	☐ No	☐ YES
3. HUD Section 8 / Other Housing Supplement	☐ No	☐ YES
4. Financial Assistance/Aid with your Medical Facility	☐ No	☐ YES
Social Worker Name & Contact Number		
5. Love Inc. Assistance	☐ No	☐ YES
6. Township Trustee Assistance	☐ No	☐ YES
7. Shelby Senior Services/Social Worker Over 60	☐ No	☐ YES
8. IWIN (Breast Cancer) \$400.00 Grant	☐ No	☐ YES
9. HOPE (Breast Cancer) \$150.00 Gift Cards	☐ No	☐ YES
10. Other - Please Explain	☐ No	☐ YES
Additional Liquid Assets		
Cash / Checking Account:	\$	
Savings Account:	\$	
Life Insurance (Cash Value)	\$	
Investments:	\$	
Retirement Funds (if not currently retired):	\$	
	TOTAL ASSETS:	\$
Requesting Assistance With:		

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Section 3: Monthly Household Expenses:

NON MEDICAL Expense Type		Estimated Expense (Monthly)
Transportation:	Car Payment	\$
	Gasoline	\$
	Auto Insurance	\$
	Taxi/Uber/ Other Transportation fees	\$
Other:	Groceries	\$
	Storage Fees	\$
	Other:	\$
Utilities:	Gas	\$
	Electricity	\$
	Water	\$
	Sewage	\$
	Home Phone	\$
	Mobile Phone	\$
	Cable	\$
	Other:	\$
Child Care:	Day care/babysitter/other	\$
Housing:	Rent/Mortgage	\$
	Home/Renters Insurance	\$
	Other:	\$
MEDICAL Expenses NOT covered by Insurance		Estimated Expenses (Monthly)
Copays/Coinsurance/Deductible Payments		\$
Monthly Premiums		\$
MONTHLY TOTAL ESTIMATE EXPENSES:		\$

SECTION 4: Signature & Acknowledgment:

I understand that any awards is made at the sole discretion of the Cancer Association of Shelby County Inc. I release the Cancer Association of Shelby County Inc. of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize the release of my name, address and medical information or other documents required by the Cancer Association of Shelby County Inc. for the purpose of verifying this application.

I also understand that I must reapply one year from the date of this application and that when I am no longer in active treatment or go under Hospice care, I will no longer be eligible for services.

Print Name	
Signature	Date:

Mailing Address: Cancer Association of Shelby County Inc., P O Box 844 Shelbyville, IN 46176 317-398-0100

Office Location: Cancer Assoc. of Shelby Co. Inc., 2311 S Miller St., Ste 500., Shelbyville, IN 46176

**SECTION 5 Medical Facility & Doctors Information:**

Family Physician	
Name:	
Address:	
Phone #:	

Oncology Physician	
Name:	
Address:	
Phone #:	

Medical Facility Providing your Cancer Care	
Name:	
Address:	
Phone #:	

(if more than 1) Medical Facility Providing your Cancer Care	
Name:	
Address:	
Phone #:	

TYPE OF CANCER:

Mailing Address: Cancer Association of Shelby County Inc., P O Box 844 Shelbyville, IN 46176 317-398-0100

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Section 6: Request for Medical Information/Patient Release

Instructions for the Patient:

Please sign your name below and deliver this form to your doctor.

I hereby consent for Dr. _____ to provide the information requested below to the **Cancer Association of Shelby County, Inc.** I understand that this information will be kept confidential and is required for consideration of my application for assistance.

Patient Signature (Parent or legal guardian if patient is a minor): _____

Date: _____

Instructions for the Physician:

Please complete the information below to the extent possible and return by **email** or **mail**.

Email: Lucinda@shelbycancer.org and Tonya@shelbycancer.org

Mail: Cancer Association of Shelby County, Inc.

P.O. Box 844

Shelbyville, IN 46176

Patient Full Name: _____

Specific Cancer Diagnosis: _____

Date Diagnosed: _____

Cancer Treatment Administered to Date (check all that apply):

- ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Immunotherapy ☐ Clinical Trial
☐ Other (list): _____
-

Patient is currently undergoing active treatment involving one or more of the following:

- ☐ Chemotherapy – IV, oral, or injection-based medications given to treat cancer
☐ Radiation therapy – external beam, internal (brachytherapy), or radioactive injections
☐ Surgery – upcoming intended to remove or reduce cancer – Surgery date _____
☐ Immunotherapy – treatments that help the immune system target cancer cells
☐ Targeted therapy – medications that act on specific genetic or molecular features of cancer

- ☐ Hormone therapy – prescribed to actively control or shrink cancer (not maintenance-only)
☐ Stem cell or bone marrow transplant – during the preparation, transplant, or recovery phase
☐ Clinical trial participation – if the trial involves active treatment of cancer ☐ Yes ☐ No
-

Future treatment required? ☐ Yes ☐ No

If yes, please provide a brief overview of the planned treatment:

Estimated period for active treatment: _____

Will treatment require travel outside of Shelby County? _____

Other comments / related expenses:

Physician's Name (please print): _____ **Date:** _____

Physician Signature: _____

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