# VERNON COUNTY CANCER RELIEF

Reaching out with Love, Hope, and Concern

PO Box 24 Nevada, MO 64772

**Must be submitted every six months or as deemed necessary by board.** Date ____________

Name ________________________ Date of Birth ____________

Address ________________________ Phone # ____________

City/State/Zip ________________________ Cell # ____________

Employer ________________________ Phone # ____________

Form completed by ________________________ Phone # ____________

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Oncologist ________________________

Address ________________________ Phone # ____________

Cancer Diagnosis ________________________

** Doctor must complete page 2 along with your consent signature **

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Insurance Coverage (check all that apply) ______ Medicare ______ Medicaid ______ Private ______ None

** Family Services must complete page 3 along with your consent signature, if you receive benefits **

Deductible ____________ Copay ____________ Food Stamp Benefit ____________

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Monthly household income ____________ # of people in household ____________

**Must include all forms of income such as child support, alimony, disability, social security etc**

______ 0 - 17 yrs ______ 18 - 64 yrs ______ 65 & up

Rent/Mortgage ____________ Utilities ____________

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Requested Services

______ Gas ______ Food ______ Utilities ______ Other

Please provide a brief statement describing your situation causing the need for assistance.

________________________________________

________________________________________

I hereby renounce and repudiate any liability on the part of the Vernon County Cancer Relief Board of Directors. I hereby certify that all information on this form is true and complete to the best of my knowledge and belief, and that I have not knowingly withheld any information.

________________________ ____________

Signature of Patient or Representative Date

The information requested in this form will be used to help the VCCR Board of Directors determine your particular financial needs or assistance. All information obtained will be treated in a confidential manner.

The Vernon County Cancer Relief Board of Directors reserves the right to deny or limit certain services to clients at its sole discretion and/or when such services are available to the client through alternative resources, such as Medicaid or Medicare.

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## Doctor / Treatment Verification

Person Requesting Services ______________________________

Phone # ______________________

Date of Birth ______________________ SS# ______________________

I hereby authorize my oncologist to release the below information to the Vernon County Cancer Relief Board.

Signature ______________________________ Date ______________________

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To be completed by your oncologist

Oncologist ______________________________

Address ______________________________

Phone # ______________________ Fax # ______________________

Cancer Diagnosis ______________________________

Treatment Plan ______________________________

Starting Date ______________________ Duration ______________________

Location ______________________

Person verifying this information and contact # ______________________________
** please print

Signature ______________________________ Date ______________________

Please fax the completed form to VCCR at 417-667-5662 or mail to PO Box 24 Nevada, MO 64772.

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## Verification of Benefits

Person Requesting Services ______________________________

Phone # ______________________

Date of Birth ______________ SS# ______________

I hereby authorize the Division of Family Services to release information to the Vernon County Cancer Relief Board.

Signature ______________________________ Date ______________

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To be complete by Family Services

# of people in household __________ ______ 0 - 17 yrs ______ 18 - 64 yrs

Household monthly income ______________ ______ 65 & over

Is this applicant on MOHealthnet? ______ Yes ______ No

** If yes, is there a spend down and the amount ______________________________

Monthly amount of Food stamps ______________

If $0 have they applied Yes / No Reason for denial ______________________

Monthly amount of Temporary Assistance ______________

Person verifying this information and contact # ______________________________
** please print

Signature ______________________________ Date ______________

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