GRANT COUNTY CANCER BOARD

Name_____Year of Cancer Diagnosis_____

Address_____City_____, SD Zip Code_____

Phone_____ Age_____

*****<u>**A CURRENT PATHOLOGY REPORT IS REQUIRED TO OBTAIN ASSISTANCE**</u>*****

I have: (_____) Private Insurance (_____) Medicare (_____) Medicaid

(_____) Secondary Insurance (_____) Prescription Coverage

I need financial assistance with:

( ) Hospital bill (enclose bill)

( ) Prescribed Medication @

( ) Bien Pharmacy

( ) Lewis Drug

( ) Clinic bill (enclose bill)

( ) Gas Card (to be picked up at ICAP office)

( ) Lodging

( ) Other _____

Please list any cancer related medications you are currently taking

_____

I understand the information I have provided will be kept confidential, but it will be made available to the core committee of It Only Takes A Spark as well as the members of the Grant County Cancer Board.

Applicant Signature_____Date_____

Mail application to:

Grant County Cancer Board
PO Box 105
Milbank, SD 57252

Funded by proceeds from
"IT ONLY TAKES A SPARK'
CANCER WALK
With
Supplemental funds provided by Thrivent Financial

FOR BOARD USE ONLY Date of Board Meeting_____ Action taken by Board_____

Updated 10/2019 Client notified of action_____ Pharmacy notified_____