

GRANT COUNTY CANCER BOARD

Name _____ Year of Cancer Diagnosis _____
Address _____ City _____, SD Zip Code _____
Phone _____ Age _____

******* A CURRENT PATHOLOGY REPORT IS REQUIRED TO OBTAIN ASSISTANCE *******

I have: () Private Insurance () Medicare () Medicaid
() Secondary Insurance () Prescription Coverage

I need financial assistance with:

- () Hospital bill (enclose bill) () Clinic bill (enclose bill)
() Prescribed Medication @ () Gas Card (to be picked up at ICAP office)
() Bien Pharmacy () Lodging
() Lewis Drug () Other _____
**Medical necessities ordered by a physician

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 _____