IT ONLY TAKES A SPARK

Name_____Year of 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 – Bills must be enclosed

( ) Prescribed Medication @

( ) Bien Pharmacy

( ) Lewis Drug

( ) Clinic bill - Bills must be enclosed

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

( ) Lodging

( ) 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 all of the core committee members of It Only Takes A Spark.

Applicant Signature_____Date_____

Mail application to:

It Only Takes A Spark
PO Box 105
Milbank, SD 57252

All applications will need to be renewed each year in August – Applications will be mailed out for the following renewal year.

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 10/2023	Client notified of action_____	Pharmacy notified_____