IT ONLY TAKES A SPARK

Name:_____ Year of Diagnosis:_____ Age:_____

Address:_____ City:_____, SD Zip Code_____

Phone:_____ Email:_____

Preferred Method of Contact:

☐ Email ☐ Phone Call ☐ Text

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

I have the following :

☐ Private Insurance
- ☐ Medicare
- ☐ Medicaid

☐ Secondary Insurance

☐ Prescription Coverage

I need financial assistance with:

☐ Hospital bill – Bills must be enclosed
☐ Clinic bill - Bills must be enclosed
☐ Gas Card-to be picked up at ICAP office
☐ Lodging
☐ Other: _____

**Medical necessities ordered by a physician

☐ Prescribed Medication @
- ☐ Bien Pharmacy
- ☐ Lewis Drug

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

FOR BOARD USE ONLY	Date of Board Meeting	Action taken by Board
	Client notified of action	Pharmacy notified

Updated 10/2025

IT ONLY TAKES A SPARK
CANCER WALK
PO BOX 105
Milbank, SD 57252

Release of Information

Name _____
Address _____
_____

Date of Birth (MM/DD/YYYY) ____/____/_____

Last four of Social Security Number _____

Client Signature _____ Date _____

Contact Number (_____)_____-_____

****

BOARD USE ONLY

To: _____
_____
_____

Account Number _____

I have applied for assistance through It Only Takes a Spark and have been approved. Please use this as my release to visit with them regarding my:

- ☐ Account
- ☐ Schedule of Appointments
- ☐ Pathology Report
- ☐ Other Medical Procedures related to Cancer

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