# Application For Assistance

Please fill in the required information below.

ELIGIBILITY: In order to be eligible for assistance you must be:
A woman diagnosed with Lung Cancer confirmed by an Oncology health care professional, actively undergoing treatment for lung cancer, a US citizen or legally in the country and living in the continental US.

## Applicant Information

**First Name _____**

**Last Name_____**

**Date of Birth_____**

**Home Address_____**

**City_____**

**State_____**

**Zip Code _____**

**Home Phone_____**

**Cell Phone_____**

**Email _____**

**Preferred Method of Contact (Ph/ Email/ Text) _____**

**What type of assistance are you In need of?_____**
**_____**
**_____**
**_____**
**_____**
**_____**

## Treatment Center Information (Hospital)

Treatment Center Name _____

Treatment Center
Address_____

City_____

State_____

Zip Code_____

Date Diagnosed
Stage – I, II, III, IV_____

Oncologist/Dr. Name_____

Oncologist/Dr. Phone_____

Oncologist/Dr. Email _____

☐ **By checking this box, I authorize LCFFYW.ORG to contact me and my treatment center for verification purposes.**

**Email:** colleen.dumas@lcffyw.org or contact@lcffyw.org

**Phone: 800-251-2840 or 281-402-1292**