Fayette County Cancer Society
P. O Box 480
Connersville, IN 47331
765-309-2314

They All Matter

Financial Aid Application

Date: _____

Patient's Name: _____

Patient's Phone_____Patient's DOB: _____

Address: _____

Husband/Wife's Name/Guardian:

_____

Contact Person: _____Phone: _____

Local Doctor: _____

Other Doctors: _____

Hospital: _____

Type of Cancer: _____

Type of Treatment (Chemo, Radiation, Other): _____

Date of First Treatment: _____

Your current benefits (Insurance, Medicare etc.):

_____

Type of Assistance Needed (Medication, Medical Bills, Transportation, Reimbursement etc.)

_____

Money is paid directly to doctors and/or medical facilities, not to the patient with the exception of transportation sheets. All invoices, except mileage sheets, that are $500 or more will be presented to the Board for approval. No reimbursements will be made for medical invoices, mileage sheets, medications, or any other services prior to the financial aid application date. (Form revised 4/18/24)

Patient Signature