

***NAC Assistance***

Patient Name: Male / Female

Address:

Phone Number:

Email Address:

Type of Cancer: How many years?

How many live in your house? How many are under 18 years of age?

Date of Birth:

If under 18 years of age, please submit parent/legal guardian name:

***HELP NEEDED WITH***:

The following will need a bill submitted with the form:

Utility Bill (electricity, heating)

Medical Bill

Dental Bill

Car Payment

Rent/Mortgage

Gas for personal vehicles

Groceries

Other

Print Name of Patient:

Signature of Patient:

Date Submitted:

**Medical Information:**

***This section must be completed by your doctor, nurse or social worker from Oncology.***

Date of Diagnosis:

Primary Cancer: Current Stage:

Is Patient in Active Treatment: Yes / No If not in active treatment, please state frequency of follow up visits:

Yearly Every 6 Months Other

Provider’s Name:

Hospital / Clinic Name:

Printed Name of Person Completing Form:

Signature of Person Completing Form:

***NOTE***:

Requests will be reviewed by the Officers and Board Members at the next meeting. These meetings will be held on the last Monday of every month, unless otherwise stated.

Personal information will not be shared with anyone outside of our organization.

All expenses that come with a bill, will be paid directly by the organization. All other expenses will be covered by gift cards.

SUBMIT TO: NAC 469 Westcott Road Danielson, CT 06239

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*OFFICE USE ONLY:*

Date Received:

Approved: Yes / No If No, why