Confidential Application

Real Help… Real Hope…

P.O. Box 1891 ~ Halifax VA 24558 ~ 434-476-2714
www.hccahope.org

Entire Application must be filled out completely and signed before services may be rendered.

Patient's Name:_____

Patient's Address:_____

City, State & Zip:_____

Patient's Home Phone:_____Cell:_____

Proof of Halifax County Residency is required. Please provide copy of Patient's valid Driver's License or other state issued ID, Tax Bill or Electric Bill

Date of Birth:_____Social Security Number:_____

Do you have Health Insurance?_____ __No_____Yes Provider:_____

Do you receive any type of Medicaid?_____No_____Yes Type:_____

Are you a Veteran?_____No_____Yes Receiving VA Travel Reimbursement?_____No_____Yes

What type of Cancer do you have?_____

Who is your Cancer Doctor?_____

Physician Address & Phone:_____

Course of Treatment: _____Chemotherapy _____Radiation _____Surgery _____Other
If Other is checked, please explain:_____

Check ONE Local Pharmacy **(that will receive up to $150 per month for Cancer related medications**) to have an account to assist with Cancer related medications:
_____Halifax Pharmacy _____CVS _____Brookneal Drug

I give permission to the following people to discuss my case:

Name/Relationship to Patient:_____Phone:_____

Name/Relationship to Patient:_____Phone:_____

I hereby certify that all the questions have been answered truthfully to the best of my knowledge. A representative of Halifax County Cancer Association has my permission to contact my physician to verify appointments.

Patient Signature:_____Date:_____

Physician Signature:_____ _____Date:_____