APPLICATION FOR FINANCIAL ASSISTANCE

NAME: ____

ADDRESS: ____

CITY: ____________________________________STATE:_____________________ZIP:______________

PHONE: ___________________________________EMAIL:______________________________________

SPOUSES NAME: _____________________________NUMBER OF CHILDREN LIVING WITH YOU: ________

I'M IN TREATMENT FOR: (PLEASE CHECK)

____UTERINE _____FALLOPIAN _____ENDOMETRIAL ____CERVICAL _____VAGINAL/VULVAR

DATE DIAGNOSED WITH CANCER: ________________________STAGE:____________________

PHYSICIAN/ONCOLOGIST: ____DOB:__________________

ARE YOU CURRENTLY RECEIVING TREATMENTS? _________________

IF NEEDED, YOU HAVE MY PERMISSION TO CONTACT MY PHYSICIAN TO VERIFY DIAGNOSIS - PLEASE INITIAL______

I'M SEEKING ASSISTANCE WITH TRANSPORTATION TO AND FROM MY MEDICAL APPOINTMENTS – PLEASE INITIAL_______

SIGNATURE: ____DATE:_________________________

Your application will remain confidential. **Also, a note from your physician or Social Services stating you are currently in treatment for cancer is required.** Gift cards for gas will be issued in $25.00 increments. Questions can be directed to 419-866-6622. Please mail your application and the required documentation to the OCC 5577 Airport Hwy. Ste. 206 Toledo, Ohio 43615

OCC contact information: 419-866-6622 ~ ovariancancerconnection@yahoo.com ~ ovarianconnection.org

We're sorry but until all women in NW Ohio & SE Michigan have their transportation needs met, we are unable to assist those outside of our area.