FINANCIAL ASSISTANCE FOR GYNECOLOGIC CANCER

PERSONAL INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

PHONE: _____EMAIL: _____

_____SINGLE _____MARRIED _____DIVORCED _____WIDOWED

NUMBER OF CHILDREN LIVING WITH YOU: _____ ARE YOU EMPLOYED: _____YES _____NO

WORKING: _____ PART-TIME _____FULL-TIME _____ RETIRED _____DISABLED

DIAGNOSIS OF: _____Ovaries_____Cervix_____Uterus_____Vulva_____Vagina_____Fallopian Tube

DATE DIAGNOSED: _____ STAGE: _____ RECURRANCE _____YES _____ NO

PHYSICIAN/ONCOLOGIST: _____DOB: _____

ARE YOU CURRENTLY RECEIVING TREATMENTS? _____YES _____NO

YOU HAVE MY PERMISSION TO CONTACT MY PHYSICIAN TO VERIFY DIAGNOSIS. PLEASE INITIAL_____

I'M SEEKING FINANCIAL ASSISTANCE FOR: (mark all that applies)

RENT/MORTGAGE: _____ I WOULD LIKE OCC TO CONTACT OTHER AGENCIES ON MY BEHALF: _____

GAS CARD: _____ PRESCRIPTION DRUGS: _____

TRANSPORTATION _____ ASSISTANCE WITH GROCERIES/ CLEANING ITEMS: _____

UTILITIES BILLS: _____ OTHER: _____

SIGNATURE: _____DATE: _____

Your application will remain confidential and acceptance will be based on need. **The OCC will provide up to $500.00 each year per person while in treatment.** Questions can be directed to 419-866-6622. Please mail your application to OCC 5577 Airport Hwy. Ste. 206 Toledo, Ohio 43615.

****** We're sorry but until all women throughout NW Ohio & SE Michigan fighting ovarian cancer have their financial needs met, we are unable to assist those outsides of our designated area.**