



2019 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: _____ RECURRENCE?: 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 apply)

RENT/MORTGAGE I WOULD LIKE OCC TO CONTACT OTHER AGENCIES ON MY BEHALF GAS CARD

ASSISTANCE WITH GROCERIES/ CLEANING ITEMS UTILITY BILLS

OTHER: _____

SIGNATURE: _____ DATE: _____

Your application will remain confidential and acceptance is 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 and other gynecological cancers have their financial needs met, we are unable to assist those outside of our designated area.