



OVARIAN CANCER CONNECTION

2021 FINANCIAL ASSISTANCE FOR GYNECOLOGIC CANCERS

PERSONAL INFORMATION:

NAME: _____ DOB _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

ARE YOU EMPLOYED: _____ YES _____ NO IF WORKING: _____ PART-TIME _____ FULL-TIME _____

CANCER DIAGNOSIS:

_____ Ovary _____ Cervical _____ Endo/Uterine _____ Vulva _____ Vaginal _____ Fallopian Tube

DATE DIAGNOSED: _____ STAGE: _____ RECURRENCE _____ YES _____ NO

PHYSICIAN/ONCOLOGIST: _____

ARE YOU CURRENTLY RECEIVING TREATMENTS? _____ YES _____ NO

MY UPCOMING TREATMENT DATES (IF AVAILABLE):

YOU HAVE MY PERMISSION TO CONTACT MY PHYSICIAN/NURSE TO VERIFY DIAGNOSIS & TREATMENT DATES.

PLEASE INITIAL: _____

I WOULD LIKE ASSISTANCE WITH:

TRANSPORTATION/GAS CARD: _____ ASSISTANCE WITH GROCERIES _____

I WOULD LIKE THE OCC TO CONTACT ME REGARDING ASSISTANCE NOT LISTED: _____ YES _____ NO

SIGNATURE: _____ **DATE:** _____

YOUR APPLICATION WILL REMAIN CONFIDENTIAL AN ACCEPTANCE IS BASED ON NEED. **THE OCC WILL PROVIDE UP TO \$500.00 IN ASSISTANCE EACH YEAR WHILE IN TREATMENT.** QUESTIONS? CALL OR TEXT 419.866.6622. PLEASE SEND YOUR APPLICATION TO **OCC 5577 AIRPORT HWY. STE. 206 TOLEDO, OHIO 43615** OR FAX TO: 888-462-6817

****** THE OCC PROVIDES ASSISTANCE TO ONLY THOSE LIVING IN NW OHIO AND SE MICHIGAN ******