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: _________________ RECURRANCE _____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****