VERNON COUNTY CANCER RELIEF

Reaching out with Love, Hope, and Concern

PO Box 24 Nevada, MO 64772 E: VCCR1987@gmail.com

Open to Vernon County, MO residents actively undergoing cancer fighting treatment

Must be submitted every six months or as deemed necessary by board. Date _____

Name _____ Date of Birth _____

Address _____ Phone # _____

City/State/Zip _____ Cell # _____

** Subject to verification **

Employer _____ Phone # _____

Form completed by _____ Phone # _____

Oncologist/Radiologist _____

Address _____ Phone # _____

Cancer Diagnosis _____ Fax # _____

** Doctor must complete page 2 along with your consent signature **

Monthly income _____ # of people in household _____

Must include all forms of income such as child support, alimony, disability, social security, etc

_____ 0-17 yrs _____ 18-64yrs

_____ 65 & up

Food Stamp Benefit _____

** Family Services must complete page 3 along with your consent signature, if you receive benefits **

Rent/Mortgage _____ Utilities _____

Requested Services

_____ Gas _____ Food _____ Utilities _____ Other

** Family Services must complete page 3 along with your consent signature, if you request food help **

Please provide a brief statement describing your situation causing the need for assistance.

_____

_____

I hereby renounce and repudiate any liability on the part of the Vernon County Cancer Relief Board of Directors. I hereby certify that all information on this form is true and complete to the best of my knowledge and belief, and that I have not knowingly withheld any information.

_____ _____

Signature of Patient or Representative Date

The information requested in this form will be used to help the VCCR Board of Directors determine your particular financial needs or assistance. All information obtained will be treated in a confidential manner.

The Vernon County Cancer Relief Board of Directors reserves the right to deny or limit certain services to clients at its sole discretion and/or when such services are available to the client through alternative resources.

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Doctor / Treatment Verification

Person Requesting Services _____

Phone # _____

Date of Birth _____ Last 4 of SS # _____

I hereby authorize my doctor to release the below information to the Vernon County Cancer Relief Board.

Signature _____ Date _____

** To be completed by your oncologist/radiologist **

Doctor _____

Address _____

Phone # _____ Fax # _____

Cancer Diagnosis _____

Treatment Plan/Scheduled Appts _____

****please attach scheduled appointments****

Actively undergoing cancer fighting treatment _____ Yes _____ No

Starting Date _____ Frequency _____

Location _____ # of treatments _____

Person verifying this information and contact # _____

Signature _____ Date _____

Please email the completed form to VCCR at VCCR1987@gmail.com or fax to 417-667-5662

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Verification of Benefits

Person Requesting Services _____

Address _____ Phone # _____

Date of Birth _____ Last 4 of SS # _____

I hereby authorize the Division of Family Services to release information to the Vernon County Cancer Relief Board.

Signature _____ Date _____

To be complete by Family Services

Number of adults in household _____ Number of children in household _____

Receive help _____ Yes _____ No Applied _____ Yes _____ No

Monthly amount of Food stamps _____

Monthly amount of Temporary Assistance _____

Person verifying this information and contact # _____

Signature _____ Date _____

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