



Web: [www.cfoa.org](http://www.cfoa.org)

E-mail: [customerservice@cfoa.org](mailto:customerservice@cfoa.org)

**(CONFIDENTIAL)**

# RENEWAL APPLICATION FOR ASSISTANCE

## Patient Information

Please print

Please answer all questions

First Name \_\_\_\_\_ Middle I. \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ County \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Email Address \_\_\_\_\_

When did you discover you had cancer? \_\_\_\_\_

Are you currently using a "G" Tube? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you able to eat solid foods? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm / dd / yyyy)

### MEDICAL INFORMATION CONSENT FOR DISCLOSURE

BY SIGNING BELOW, I (THE PATIENT/APPLICANT NAMED ON THIS APPLICATION FOR ASSISTANCE) HEREBY AUTHORIZE MY PHYSICIAN AND/OR HEALTHCARE PROVIDERS TO RELEASE INFORMATION TO THE CANCER FUND OF AMERICA AND ITS REPRESENTATIVE AGENTS TO THE EXTENT NECESSARY FOR THE SOLE PURPOSE OF CONFIRMING THAT I HAVE BEEN DIAGNOSED WITH CANCER AND HAVE BEEN TREATED AND AM STILL IN NEED OF THE ASSISTANCE THAT THE CANCER FUND OF AMERICA IS PROVIDING. ALL PATIENT INFORMATION OBTAINED BY THE CANCER FUND OF AMERICA, EITHER FROM HEALTHCARE PROVIDERS, THE PATIENT, OR THE PATIENTS FAMILY WILL BE KEPT STRICTLY CONFIDENTIAL AND USED SOLELY FOR THE PURPOSE OF ASCERTAINING NEED AND PROVIDING APPROPRIATE ASSISTANCE TO THE EXTENT POSSIBLE.

PATIENT'S SIGNATURE \_\_\_\_\_

(IF ANOTHER INDIVIDUAL WITH MEDICAL POWER OF ATTORNEY, PLEASE ATTACH POA DOCUMENTATION.)

- THIS INFORMATION IS NEEDED EXCLUSIVELY FOR GUARDING AGAINST FRAUDULENT APPLICATIONS. YOUR COOPERATION IN THIS EFFORT IS APPRECIATED.

## **MEDICAL... THIS SECTION IS TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY**

**\*\*\*THE PERSON LISTED HEREIN IS REAPPLYING FOR ASSISTANCE \*\*\***

TYPE OF CANCER \_\_\_\_\_  
(GENERAL DIAGNOSIS, STATUS, ETC.)

STAGE **0 1 2 3 4**  
(please circle one)

SIGNATURE \_\_\_\_\_ PROF. TITLE \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Note: We provide liquid nutrition (like Boost, Carnation, Sustical, etc.) to individuals with cancer and to those that are in remission who are still in need of this type of product. Please use your professional opinion in this matter so that we can continue to serve those in need.

COMMENTS \_\_\_\_\_

For additional information, call.... (800) 578-5284

**Cancer Fund of America, Inc.**

2901 Breezewood Lane Knoxville, TN 37921-1099

... our primary mission is to help indigent patients nationwide ...

### **FOR CFA OFFICE USE ONLY**

Existing Patient ID Number: \_\_\_\_\_

Date Received: \_\_\_\_\_ Code: \_\_\_\_\_

individual patient / non-profit hospitals / home health care / institutional