

Cancer Association of Anderson  
215 E Calhoun Street, Anderson, SC 29621  
Phone: 864-222-3500 Fax: 864-222-3502 Email: Kathy@CAanderson.org

**APPLICATION FOR SERVICE**

Today's Date \_\_\_\_\_ Last 4 Social # \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (PO Box) if different: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # in Household: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Any other people who may contact us on your behalf: \_\_\_\_\_

Referred by: \_\_\_\_\_ Patient's cancer doctors: \_\_\_\_\_

Type of cancer \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Insurance Coverage: Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Indigent \_\_\_\_\_ None \_\_\_\_\_

Private insurance (name of company or plan) \_\_\_\_\_

Other \_\_\_\_\_

**This information assists us with potential donors and grants. We do not share personal information with any other organization. Your information is confidential.**

Where do/did you work or what is your source of support (Patient): \_\_\_\_\_

Where does/did your spouse work or what is their source of support (Spouse): \_\_\_\_\_

Name of church you attend: \_\_\_\_\_

Veteran: Yes \_\_\_\_\_ No \_\_\_\_\_ Branch: \_\_\_\_\_

**Cancer Association of Anderson Release Statement**

I understand that by signing this statement, I give the CAA permission to assist me with community referrals and/or networking with other cancer patients, and if necessary, the pursuit of insurance related matters through designated carriers. This consent also includes any release or exchange of information needed by CAA staff members or volunteers for requested assistance on my behalf. I understand that this consent may be revoked by me or my representative at any time. I also give permission for the CAA to obtain health information from my doctor.

CAA may send correspondence to the address or e-mail address indicated on this application: Yes \_\_\_\_\_ No \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If client is unable to sign, client's personal representative must sign below.**

Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_