CANCER SUPPORT COMMUNITY
GREATER ST. LOUIS

(formerly The Wellness Community)

Staenberg Family Foundation Cancer Services
REQUIRED FOR ASSISTANCE

- **Intended for people with a cancer diagnosis who are financially IN NEED.**
- **Generally, patients with annual household incomes under $50,000 are eligible for assistance. If you feel you have an exceptional situation, please submit application along with all other pertinent information.**
- **MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING THIS APPLICATION.**

APPLICANT INFORMATION

☐ **Female** ☐ **Male** **TODAY'S DATE** _____

NAME: _____ **PHONE:** _____

ADDRESS: _____ **DATE OF BIRTH:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CANCER DIAGNOSIS: _____ **DATE DIAGNOSED:** _____

ETHNICITY: ☐ White ☐ Black/African American (non Hispanic) ☐ Black/ African American (Hispanic) ☐ White (Hispanic) ☐ Asian ☐ American Indian or Alaska Native ☐ Other

CAREGIVER CONTACT INFORMATION (*if applicant is unable to provide information*)

NAME: _____ PHONE: _____

RELATIONSHIP TO APPLICANT: _____

TYPE OF ASSISTANCE REQUESTED *(must be directly related to cancer diagnosis)*

☐ Breast Prosthesis ☐ Bra ☐ Wig

☐ Lymphedema Item(s): ☐ Sleeve ☐ Glove ☐ Other _____ ☐ Left ☐ Right ☐ Both

☐ Nutritional Supplement (specify type): _____ Flavor: _____

☐ Incontinence Products (specify): _____ Size (if applicable): _____

☐ Other Medical Items (specify): _____

SOURCE OF REFERRAL

Health Care Professional Making Referral (Print): _____

Title/Position _____

Email: _____ Phone: _____

Hospital/Organization: _____

REQUIRED:

ANNUAL HOUSEHOLD INCOME: ☐ Under $25,000 ☐ $25,000 - $49,999 ☐ $50,000 - $74,999 ☐ $75,000-99,000 ☐ $100,000+ # IN HOUSEHOLD: ____

APPLICANT HAS *(check all that apply)*: ☐ Medicare ☐ Medicaid ☐ Private Insurance _____ ☐ No coverage

Is there **full** or **partial** insurance coverage for this item through any of the above? ☐ NO ☐ YES

If **YES**, details of coverage: _____

EMPLOYMENT STATUS: ☐ Employed full or part time ☐ On medical Leave ☐ Disabled ☐ Not employed ☐ Retired

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To the best of my knowledge, the information provided herein is accurate and complete. This is a Release of Information.

Signature of Health Care Professional: _____ ***Date:*** _____

Signature of Applicant (or Caregiver): _____ ***Date:*** _____

FAX OR MAIL TO: CANCER SUPPORT COMMUNITY OF GREATER ST. LOUIS *(FORMERLY THE WELLNESS COMMUNITY)*
1058 OLD DES PERES RD., ST. LOUIS, MO 63131 ◆ PHONE: 314-238-2000 ◆ FAX: 314-909-9900