

CANCER FOUNDATION LEAGUE REFERRAL INFORMATION

301 Hall Street
Monroe, LA 71201
318-460-1006
Fax: (318) 460-1009

Patient must live in NE Louisiana or being treated in NE Louisiana.

REFERRAL SOURCE:

Name: _____ Date of Referral: _____
Phone: _____ Relationship: _____
Agency Affiliation: _____

PATIENT INFORMATION:

Name: _____ SS#: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Parish: _____
Daytime Phone: _____ Alternate Daytime Phone: _____
Diagnosis: CANCER OF _____
Date diagnosed: _____

***MUST PROVIDE PATHOLOGY REPORT FOR VERIFICATION OF DIAGNOSIS OF CANCER.**

Receiving medical care at:

1) _____ Physician's Name: _____
Type of treatment at this time: _____
2) _____ Physician's Name: _____
Type of treatment at this time: _____

HOUSEHOLD INFORMATION: List ALL persons who are LIVING WITH THE PATIENT.

Name	Age	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCOME: List ALL SOURCES of TOTAL household income AND include AMOUNTS OF EACH SOURCE OF INCOME. (Includes employment, SS, SS Disability, SSI, Food Stamps, other)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Total Household Income: _____ **(MUST ATTACH PROOF OF INCOME)**
(example – check stub, W2, bank statement, Social Security letter)

Medicare #: _____
Medicaid #: _____
Private Insurance: Yes _____ No _____ Prescription Coverage: Yes _____ No _____
Supplemental or Cancer Policy: _____
Veterans: _____ Hospice: _____

Monthly rent: \$ _____ (or) Monthly mortgage: \$ _____

Are you receiving help from any other organization at this time? Yes _____ No _____
Name: _____ Type of help: _____ \$ amount: _____

Have you ever received assistance from CFL before? _____ When? _____

STATISTICAL INFORMATION: (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE _____ SEX _____ NATIONALITY _____

This request is for help with: (Check appropriate one)

- _____ Prescription medications
- _____ Medical supplies
- _____ Transportation to/from Treatment (gas cards) chemo & radiation treatments only
- _____ Nutritional Supplements
- _____ Other services (Explain) _____

CFL DOES NOT PAY MEDICAL BILLS (DOCTOR, HOSPITAL, TREATMENTS, ETC.)
CFL DOES NOT PAY PHONE, CABLE BILLS OR UTILITY DEPOSITS.

The patient agrees to defend, indemnify, and hold harmless the Cancer Foundation League and its officers, directors, members, and all volunteers from and against any claims, demands, causes of action, damages, or liabilities, or any cause whatsoever, including reasonable attorney's fees. This referral may be amended at any time and is limited to funds available for distribution.

Patient's Signature

Date

****The Cancer Foundation League and the Louisiana Cancer Foundation ARE NOT affiliated with any national cancer organization. We provide assistance to any cancer patient who lives in or is receiving treatment in Northeast Louisiana.***

Please note: The application will not be considered unless all sections are filled out and requested documentation is provided.