

# CANCER FOUNDATION LEAGUE REFERRAL INFORMATION

411 Calypso Street  
Monroe, LA 71201  
318-966-1953 or 1-800-393-2029  
Fax: (318) 966-1952

(PRINT OR TYPE LEGIBLY)

## 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: \_\_\_\_\_  
Is patient aware of diagnosis? \_\_\_\_\_ Family? \_\_\_\_\_

**\*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

\_\_\_\_ Nutritional Supplements

\_\_\_\_ Other services (Explain) \_\_\_\_\_

**CFL DOES NOT PAY MEDICAL BILLS (DOCTOR, HOSPITAL, 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 the American Cancer Society. 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.***