APPLICATION FOR CANCER ASSISTANCE

Date of Application _____

Date of Diagnosis _____

Date of Update _____

1. Name of Patient requiring aid _____ Age _____

2. Is Patient requiring aid a member of the Order of the Eastern Star? _____

3. Address _____
   (street) (city) (zip code) Telephone
   _____ Birth date _____

4. Name of Applicant Member _____
   Relationship to Patient _____
   a. Member of _____ Chapter No. _____ Located at _____
   b. Member Number _____
   c. Length of Membership in this Chapter _____ Length of Membership in California _____
   d. Is this the first application for assistance? ❑ yes /❑ no

5. Medical Insurance Carrier _____
   Policy Number _____ Group Number _____
   Address _____
   Telephone _____
   Medicare/Social Security Number _____

6. Applicant may be contacted on _____ at _____
   (date) (time and place)

This application shall be accompanied by a separate medical report by a licensed Doctor of Medicine indicating the diagnosis and the date of diagnosis. All subject matter herein contained shall be considered confidential. I hereby give my permission for the Order of the Eastern Star to contact my medical care providers for information regarding my diagnosis, treatment, and account status.

Signature of Applicant: _____

For use by the Committees

Date Received: _____

Approved: _____ Date: _____
Cancer Assistance Chairman

Amount Approved: $_____ Fund: _____ Date Applicant Notified: _____