Date Received by ASCCC: ______________ Staff Initials: ______
Date Application Approved: _____________ Date Check Requested: ___________
CHECK #_________ CHECK DATE: ______________

American Samoa Community Cancer Coalition

Demographic Information:

First Name ______________________________Last Name_________________________________

Address: (P.O. Box) _________________ Village______________________

Phone Number: ______________Cell Number:________________Other Number:____________________

Date of Birth: ____/____/____ **Place of Birth**: ☐ American Samoa Other:____________________

Please check appropriate boxes:

☐ **Male** ☐ **Female** **Religion:** ☐ Catholic ☐ LMS ☐ LDS Other: ___________________

Marital Status: ☐ Single/Widowed ☐ Married ☐ Divorced ☐ Separated

Ethnicity: ☐ Samoan ☐ Tongan ☐ Fiji ☐ Korean Other: ________________________________

Employment: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student

Has Applicant ever been in the **Military**? ☐ Yes ☐ No

Application Process:

Patient must provide the following items:

Verification of **confirmed cancer diagnosis** through medical records

1. Doctor's medical professional opinion (documentation from a physician regarding patient illness, diagnosis of cancer, how long patient has been diagnosed, proposed plan of treatment, etc). **OR**
2. Official test result or medical record stating the diagnosis of cancer

What type of cancer do you have? ____
When were you diagnosed? ______________________________
Where were you diagnosed? ____

Will you have the following done?

○ Surgery (If so where?)_______________________________________
○ Chemotherapy (If so where)____
○ Oncology (If So where?) ____
○ Palliative (If so where?) ____
○ Off- Island Referral to be seen by a physician for diagnosis?

Is this your first time applying for assistance through the ASCCC? ☐ Yes ☐ No

If No, when was the last time you applied for assistance? ________________

How were you referred to the ASCCC Program (please check one):

- ○ ASCCC Member (name:____)
- ○ Family Member: (name:____)
- ○ Friend (name:____)
- ○ Department of Health/ LBJ Staff/Doctor (__________________________________)
- ○ Advertisement (radio or News Paper ad)
- ○ ASCCC Community Event (please list event) ______________________________________

IMPORTANT PATIENT/APPLICANT AUTHORIZATION AND ACKNOWLEDGEMENT:

I authorize <u>the release of any medical or other information necessary to process this application</u> to the ASCCC (American Samoa Community Cancer Coalition). The information that ASCCC obtains will be used to determine eligibility of the applicant. I understand that the information may also be used to provide statistical data information for the ASCCC and will become the property of the organization.

I authorize the ASCCC to <u>publicly use my name and photo</u> to inform donors about my stipend award should my application be approved.

I acknowledge that the <u>ASCCC cannot provide a stipend to a Patient/Applicant's family if this person has passed away before receiving the stipend</u>.

I acknowledge that stipends are provided in the form of a bank check made payable to the Patient/Applicant or parent of a minor Patient/Applicant.

I acknowledge that my application will be on a waitlist until donation funds are available to pay out a complete stipend, and that the waitlist is on a first-in first-out priority <u>based on the date this application is approved</u>.

I acknowledge that by typing in my name electronically, it is as valid as an actual authorized signature. My signature certifies that the foregoing information is true, accurate and complete.

Print Patient's Name_______________________ Patient's Signature_____________________________

Date_____________________

If Patient is unable to sign:

Authorized Party's Name_____________________ Authorized Party's Signature____________________

Date_____________________