Date Recieved	_____	Received By	_____	Voucher Approved	_____
Check Date	_____	Check #	_____	Date Released	_____

OFFICE USE ONLY

AMERICAN SAMOA COMMUNITY CANCER COALITION

First Name _____ Last Name _____

Address _____ Village _____

Cell _____ Home _____ Other _____

Birthdate _____ Place of Birth ☐ American Samoa ☐ Other _____

Email _____

**Please check the appropriate boxes

Gender: ☐ Male ☐ Female

Religion: ☐ Catholic ☐ SDA ☐ LMS ☐ Other _____ ☐ LDS

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

Race: ☐ Samoan ☐ Tongan ☐ Fijian ☐ Filipino ☐ Other _____

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

Has the applicant ever been in the military? ☐ **Yes** ☐ **No**

Application Process:

The 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 the 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 one of the following done? If so, where?

☐ Surgery _____

☐ Chemotherapy _____

☐ Oncology _____

☐ Palliative _____

☐ Off Island Referral to be seen by a physician for diagnosis?

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

If no, when was the last time that you applied for assistance? _____

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

- ☐ ASCCC Member
- ☐ Family Member
- ☐ Friend
- ☐ Department of Health/ LBJ Staff / Doctor
- ☐ Advertisement (Radio, Newspaper, Social Media)
- ☐ ASCCC Event

IMPORTANT PATIENT/ APPLICANT AUTHORIZATION AND ACKNOWLEDGMENT:

I authorize the release of any medical or other information necessary to process this application to the ASCCC (American Samoa Community Cancer Coalition). The information that ASCCC obtains will be used to determine the 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. The ASCCC may publicly use my name and photo to inform donors about my stipend award should my application be approved. I also understand that by typing in my name electronically, it is as valid as an actual authorized signature. I understand that the ASCCC cannot provide a stipend to a patient /Applicant's family if this person has passed away before receiving the stipend. I understand that stipends are provided in the form of a bank check made payable to the Patient/Applicant or parent of a minor Patient/Applicant. This also 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 Name **Authorized Party's Signature**

_____ _____

Relationship to Patient **Date**

Please attach ONE of the following documents confirming cancer diagnosis

1. **Doctor's signed letter on hospital letterhead stating a confirmed diagnosis**
   OR
2. **Medical record reflecting diagnosis (must have patient's name and Medical Record Number (MRN) or other identifying data.**