



223 Riverview Dr. Suite J
Danville, VA 24541
(434) 791-3227
(434) 791-4815 – FAX
www.danpittcancer.org
danvillecancer@gmail.com

CONFIDENTIAL CLIENT APPLICATION FORM

Client's Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Date of Birth:** _____

Type of Cancer _____ **Date of Diagnosis** _____

Oncology Physician _____ **Phone** _____

Oncologist's Address _____

What type of treatment are you receiving? (Please circle): Chemo Radiation Other _____

Where are you taking your treatments? (Medical Facility): _____

Are you receiving any other assistance? (Please circle): Yes No

If yes, from what organization? _____

Does client have? (Please circle): Medicare Medicaid SSI/SSDI Disability Pension
Unemployment Income Veteran Employer Insurance None Other _____

***Do you have cancer insurance? (Aflac, Mutual of Omaha, etc.):** Yes No

Is there any other authorized person that we may contact regarding your care? If so list below:

Name _____ **Phone** _____

I, _____ do hereby authorize Danville-Pittsylvania Cancer Association, Inc. its employees and/or volunteers to contact my physicians, medical facilities, and pharmacies to confirm my cancer related needs. I certify that all of my information is true and complete to the best of my knowledge. I understand that DPC may revoke my services at any time. I will notify DPC if any of my information changes. Any act of fraud will result in immediate suspension of services and may result in civil action or criminal prosecution. This release is in accordance with any and all healthcare laws.

Signature _____ **Date** _____

DPC Rep. _____ **Date Received** _____



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Statistical Questionnaire
(used for grant purposes only)

Total annual household income: _____

Ethnicity (please circle): White African American Hispanic/Latino

Native American/American Indian

Asian/Pacific Islander

Other _____

Gender (please circle): Male Female

Number of people in household (including dependents): _____