Gifts for Living

Application for Financial Support
ONCOLOGY and/or HEMATOLOGY PATIENTS

Name : _____ Date: _____

Phone: _____ E-mail: _____

Address: _____

Date of Birth: _____

Physician: _____ Physician Phone: _____

Describe financial situation and assistance requested (attach page if additional space is needed: _____

_____

_____

_____

OTHER AGENCIES CONTACTED:

____ Wyoming Cancer Resource (307) 633-7136 *(Albany County)*
____ Wyoming Cares (866) 996-6564 *(Casper)*
____ Downtown Clinic (307) 745-8445
____ Volunters of America (307) 672-0475
____ Other _____

____ Interfaith (307) 742-4240
____ LIEAP (307) 472-4221 *(Help with Utilities - Applications only taken at certain times of the year/ help only through winter months)*
____ WIND (307) 721-7275 *(Disability assistance - also check uuyo.edu/AtoZ directory)*
____ Soup Kitchen (307) 460-1605
____ Angels Cancer Care Program - 1233 2nd St. Casper, WY 82601 (307) 577-4355 *(State wide $100 limit per year)*

I hereby grant permission to Dr (s). _____ to release information to the representatives from Gifts for Living Inc. Application Committee regarding my physical condition, prognosis, and /or diagnosis if it is deemed necessary for the application process.

Patient signature _____

Please mail application to: Gifts For Living, Inc., P.O. Box 1005, Laramie, WY 82073

Gifts For Living, Inc. use only:
We have reviewed and approved/disapproved this application. Please disperse: _____

_____

Printed Name/Date _____ Printed Name/Date _____
Signature _____ Signature _____