



CANCER ASSISTANCE APPLICATION FORM

Name of Patient

Last Name	First Name	Middle Name	Date of Application
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Birthday**Age****Endorsed By / Date**

Birthday	Age	Endorsed By / Date
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Requested by

Requested by	<input type="checkbox"/> JEC	<input type="checkbox"/> JCAI	<input type="checkbox"/> CGTFI
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Relationship to Patient

<input type="checkbox"/> SPOUSE	<input type="checkbox"/> PARENT	<input type="checkbox"/> CHILD	<input type="checkbox"/> RELATIVE	Contact Number
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 First Application Second Application Third Application1st Application Date mm/dd/yyyy2nd Application Date mm/dd/yyyy**Purpose** For Chemotherapy For Radiation For Palliative Chemotherapy For Immunotherapy For Surgery Other Approved by CGTFI Health Committee **Requirements Checklist**

1. Medical Abstract from attending physician
2. Supporting diagnostic results (e.g., laboratory test, MRI, scan, xray)
3. Photocopy of government issued ID of patient
4. Authorization Letter and photocopy of government-issued ID, if representative (only immediate family member) to receive check

5. Letter of authorization from patient. If needed to deposit check to patient's bank account:
Bank Details (Account Name / Number)

6. After receipt of check, submit an acknowledgement letter / thank you note indicating amount received & utilization of the amount.

Documents Received By

KRISTYLLE MAE D. PASCUAL Signature / Date
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Approved for Check Release

EVELYN M. BUMATAY Executive Director Signature / Date
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Check Received By

Signature over printed name / Date
