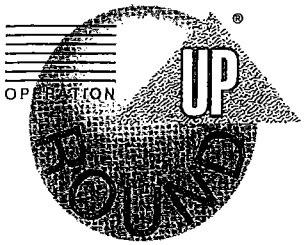

Wayne-White Operation Round-up Kare & Share
WORKS
P.O. Box 700 • Fairfield, IL 62837

DENNIS SCRANTON MEMORIAL CANCER FUND

Eligibility Requirements:

1. Must live in Wayne White Electric service territory and must have resided in the territory for at least one (1) year.
2. Assistance must be for **current cancer treatment.** Assistance will not be provided retroactively for completed cancer treatments. Active treatment is defined as in surgery and follow up to surgery, radiation and chemotherapy.
3. **Health Care provider (physician or oncologist) must sign the patient's application form affirming that the patient is in active cancer treatment.**
4. Application form must be completed in full and submitted to the address below or it will be returned to the applicant. The Dennis Scranton Memorial Cancer Fund tries to assist as many patients as possible within our territory. The fund relies solely on funds from generous donors and individual donations and as stewards of these funds we review every application and make the funds available to those who meet the qualifications. The funds are provided based on the information provided on the application and the anticipated financial hardship of the individual applying for funds.

PLEASE PRINT CLEARLY. ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS APPLICATION.

Application Date_____
Name_____ **Address**_____
City_____ **State**___ **Zip Code** _____ **Home Phone**_____
Work Phone_____ **Cell Phone**_____
Gender: Male__ **Female**__ **Date of Birth**_____
Dependents: Y/N___ **Marital Status:** _____

Financial Information:
Are you currently employed: Y/N___ **Monthly Income/all sources:**_____
Estimated Monthly Expenses
Rent/Mortgage_____
Utilities/Phone_____
Childcare_____
Transportation_____
Medical Bills_____
Food_____
Other Debt_____
TOTAL_____

Patient Statement: I certify that I am **currently** a cancer patient undergoing treatment. I am in need of this assistance program for my cancer treatment. **I further certify that other forms of assistance such as insurance, Medicare or Medicaid benefits do not pay for transportation, food or lodging for my cancer treatments.** I further certify that if I receive assistance from the Dennis Scranton Memorial Cancer Fund that such assistance will be used **only** for food, lodging or transportation related to cancer treatment.

Signature: _____ Date_____

To be filled out by physician/oncologist: Clinic Name_____
Type of Cancer_____ Stage at diagnosis (if known) _____ In active treatment: Y/N _____
If yes please indicate type of treatment:_____
Doctors Signature:_____ Phone Number_____

Please complete the entire form and return to: **Dennis Scranton Memorial Cancer Fund**
P O Box 700
Fairfield, IL 62837