Date ____________ Client ID______________

Ashland County Cancer Association Client Registration Form

Name ________________________________ Phone Number ________________________

Date of Birth ___________________________ Twp. _________________________________

Address ______________________________________ City/ZIP ________________________

Email Address ____

Contact Person/Next of Kin _______________________ Relationship______________________

Address ______________________________________ City/ZIP ________________________

Phone Number _________________________________

Do you wish to receive our newsletter?___________ Choose one: ☐ Mail ☐ Email

How did you hear of the Ashland County Cancer Association? (Please check all that apply)

☐ Friend ☐ Family ☐ Social Media (Facebook/Web/Other) ______________________________

☐ Physician's Office_______________________ ☐ Event _________________________________

Have you seen the ACCA video? If so, where? ____

Medical Information

Family Dr. ____________________________ Oncologist ____________________________

Hospital/Treatment Center ____

Diagnosis/History/Treatment ____

Demographic Information

Your household income and the number of people in your household are **required** for the statistics ACCA must provide for grants. There is no income threshold for assistance.

Number of People in Household _____ **Approximate Household Income:** $ _____________

Employed: ☐ Yes ☐ No ☐ Retired **Veteran:** ☐ Yes ☐ No **Insurance:** ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No ☐ Pending **Medicare:** ☐ Yes ☐ No ☐ Pending

Medicare Part D: ☐ Yes ☐ No **Hospice:** ☐ Yes ☐ No ☐ Pending

Ethnicity: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Native American ☐ Asian/Pacific Islander

☐ Multiracial ☐ Other ____________________

Form may be faxed to (419) 281-5743, emailed to AshlandCoCancer@gmail.com,
or mailed to 1011 East Main Street, Suite B, Ashland, OH 44805

Agency Use Only:

Information sent by: ☐ Mail ☐ In person ☐ Phone ☐ Fax

Referrals to: ☐ BCCP ☐ BCFO ☐ Hospice ☐ PMAP ☐ Medicaid ☐ MC/QMB/LIS ☐ Other ☐ Veteran Services

LiveStrong Bag Date: ____________________ Diagnosis Sheet Given/Mailed Date: ____________________