Transportation Assistance
APPLICATION

Women's Cancer Care

To apply for assistance, please complete all questions.

First Name :

Last Name :

DOB : ☐☐/☐☐/☐☐☐☐

RACE :
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ Two or More Races
- ☐ Decline to Answer

ETHNICITY:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Decline to Answer

Home Address :

Phone Number :

E-Mail :

Total Monthly Household Income :

*Proof of income may be required

Total # of Household Guests :

Do you have health insurance? : ☐ Yes ☐ No

Type of Health Insurance :
- ☐ Medicare
- ☐ Medi-Cal
- ☐ Private
- ☐ Other: _____

Cancer Site :

Guidelines:

1. Are you a Women's Cancer Care patient in active treatment? ☐ Yes ☐ No
2. Do you have transportation assistance or mileage reimbursement available through your insurance provider? ☐ Yes ☐ No
3. What type of transportation assistance would be most useful for you?
   - ☐ Gas Card
   - ☐ Ride Share Rides (Uber & Lyft)
   - ☐ Non-Emergency Medical Transport

*Patients that are awarded transportation assistance are allowed up to $500 of assistance per grant cycle while funds are available.

Patient Signature :

Date :

For Office Use:

Employee Name: _____

Date Received: _____ Date of Distribution: _____

Distance in Miles Patient Travels to WCC: _____ Type of Assistance: _____

Frequency of Treatment: _____ Amount to be Distributed: _____