United Way
United Way of Eastern Utah

LIVE.LOVE.LOCAL
Cancer Assistance Program

APPLICATION FOR FINANCIAL ASSISTANCE		
APPLICANT INFORMATION		
Name:		Referred by:
Date of birth:	Email:	Phone:
Current address:		
City:	State:	ZIP:
Have you received or are you planning to receive assistance from another entity? If so, from whom?		
EMPLOYMENT/FINANCIAL INFORMATION		
Current Employer:		How long employed?
Phone:	Email:	Annual Income:
City:	State:	Position:
EMERGENCY CONTACT		
Name of a relative or friend not living with you:		
Address:		Phone:
City:	State:	ZIP:
Relationship to you:		
MEDICAL		
Diagnosis:		Insurance Provider:
Date Diagnosed:	Physician:	Physician's Phone:
Please briefly tell us about yourself and why you are requesting help.		
SIGNATURES		
By signing below, I state that the information I have given is correct. If this information is false, I understand that I could be denied assistance and prosecuted for fraud. I give permission to United Way Cancer Assistance Committee to verify this information (including by calling my provider) and share and gather additional information that may be deemed necessary or helpful to complete the applicant review process. I give my provider permission to share my diagnosis with United Way of Eastern Utah.		
Signature of Applicant:		Date:
Approval Signature:		Date: