



**2880 NW Stewart Parkway #202  
Roseburg, OR 97471  
(541) 440-9409**

## **Services Offered:**

- Transportation Assistance
- Financial Assistance
- Nutritional Supplements
- Head Coverings (Wigs, Hats, Turbans, Scarves)
- Bras and Prosthesis
- Medical Equipment Referral

***Services offered by Douglas County Cancer Services (DCCS) are determined by the following criteria:***

- The patient must be a resident of Douglas County.
- The patient must currently be undergoing treatment for a cancer diagnosis.
- Financial need of the patient.
- The Request for Services must be completed in its entirety and signed by the patient and medical professional.
- Financial disclosure must be completed and proof of income may be requested.
- If able, the patient must present themselves to request and receive services.
- Financial assistance will be determined on an individual basis and is based on available funding.

***The following services may be provided to patients undergoing cancer treatment when the above criteria are met and a completed Request for Services is submitted:***

### **Transportation Assistance**

- A gas card may be provided if the patient travels more than 30 miles (round trip) for medical appointments and/or cancer treatments.
- Other available resources have been researched i.e., Community Cancer Center van for radiation treatments.

### **Financial Assistance**

- Financial aid to assist with living expenses such as utilities, rent or groceries may be available and is dependent upon funding.

### **Nutritional Supplements**

A referral from the Community Cancer Center nutritionist must be provided.

### **Head Coverings**

Wigs, turbans, hats and scarves are provided to cancer patients and survivors

### **Prosthesis**

Bras and prosthesis are provided to breast cancer patients and survivors.

### **Medical Equipment**

- Medical equipment such as cane, wheelchair, walker, etc. may be available for loan to patients undergoing cancer treatment.
- If approved and/or requested item is available, a referral will be given to the patient to obtain requested medical equipment from medical equipment supplier

- *All services are dependent upon available funding.*
- *A listing of resources may be provided for your research for further assistance.*
- *A new Request for Services must be completed each time services are requested.*
- *All lines on the Request for Services (RFS) form must be completed. If the form is incomplete, delays in processing and approval may occur.*
- *Monthly income and expense information must be completed in its entirety on a yearly basis.*
- *A copy of the bill must be provided if requesting funds for living expenses, utilities, phone, etc.*
- *If approved, all payments made by DCCS for living expenses, utilities and phone will be paid directly to the bill provider.*
- *Requests for Services are reviewed by the officers of DCCS Board of Directors.*
- *Final determination is based upon completion of Request for Services, total household income and necessary expenses.*
- *To ensure the most efficient process, patients are encouraged to down-load and complete the Request for Services (RFS) form online at [dccancerservices.com](http://dccancerservices.com)*
- *When form is completed and signed by medical professional you may scan and submit via email to [dccancerservices@hotmail.com](mailto:dccancerservices@hotmail.com)*
- *Douglas County Cancer Services is not meant to provide assistance on a regular basis and is a temporary funding source.*

**I have read and agree to the terms and conditions stated above.**

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**Patient Signature**

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**Date**

*Douglas County Cancer Services does not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, sexual orientation or military status.*



DOUGLAS COUNTY CANCER SERVICES (DCCS)  
2880 NW Stewart Parkway, Suite 202  
Roseburg, OR 07471  
(541) 440-9409

**Request For Service (RFS)      Date Received \_\_\_\_\_**

How did you hear about Douglas County Cancer Services? \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
*(Please print)*

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Are you a Veteran? Yes \_\_\_ No \_\_\_

**Service(s) Requested**

Wig/Hat/Turban/Scarf (specify)	
Breast Prosthesis (Size)	
Medical Equipment (specify)	
Cancer Diagnosis _____	Treatment Dates _____
<b>Items requested above DO NOT require a completed financial statement but DOES require a signature on the backside of this RFS form.</b>	
Food Card (specify amount)	\$
Gas Card (specify amount)	\$
Financial Aide (specify amount)	
Rent	\$
Utilities	\$
Other _____	\$
Do you have Health Insurance? Yes No	Name of Insurance Co.:

**\*\*See other side for patient completion of financial information - must be updated yearly\*\***

**DO NOT COMPLETE BELOW THIS LINE - TO BE COMPLETED BY MEDICAL PROFESSIONAL ONLY**

Diagnosis: \_\_\_\_\_

Treatment: Chemotherapy \_\_\_\_\_ Radiation \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_ Treatment End Date: \_\_\_\_\_

Treatment Physician Name Printed: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Professional Name Printed: \_\_\_\_\_

Medical Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Number in household? \_\_\_\_\_ Ages in Household: \_\_\_\_\_

**TOTAL MONTHLY INCOME FOR ENTIRE HOUSEHOLD**

<b>INCOME and/or ASSISTANCE</b>	<b>SELF</b>	<b>OTHERS IN HOUSEHOLD</b>
Personal Income, ie; Salary; Self-employed		
Social Security		
Social Security Disability		
VA Pension/Disability		
State		
Federal		
County		
Other i.e.; WIC; SNAP; Church, UCAN		
<b>TOTAL MONTHLY HOUSEHOLD INCOME</b>		

*How does your diagnosis and treatment(s) affect your monthly income?* \_\_\_\_\_

**Monthly Living Expenses:**

**Home:** Own: \$ \_\_\_\_\_ Rent: \$ \_\_\_\_\_ **Food:** \$ \_\_\_\_\_ **Medications/Medical Expenses for patient only:** \$ \_\_\_\_\_

**Utilities:** Gas: \$ \_\_\_\_\_ Electricity: \$ \_\_\_\_\_ Water: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_

**Automobile:** Payment: \$ \_\_\_\_\_ Gas: \$ \_\_\_\_\_ Maintenance: \$ \_\_\_\_\_

**Insurance:** Life: \$ \_\_\_\_\_ Health: \$ \_\_\_\_\_ Auto: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

**Other Household Expenses:** (i.e.; clothing, child care, school, entertainment, etc.) \$ \_\_\_\_\_

**TOTAL HOUSEHOLD LIVING EXPENSES:** \$ \_\_\_\_\_

By signing and dating below, I agree that I have read and understand the instructions and criteria for receiving services from DCCS, and that all the information provided is true and accurate.

Print Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*By initialing and entering date in box below, I have reviewed income previously provided and certify it is current and accurate.*

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