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.

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 (rent/mortgage, utilities, phone, etc.)***
- ***If approved, all payments made by DCCS for living expenses (rent/mortgage, utilities, phone, etc.) 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***
- ***When form is completed and signed by medical professional you may scan and submit via email to 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.

_____ _____

Patient Signature **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** _____
Items requested above DO NOT require a completed financial statement but DOES require a signature on the backside of this RFS form.	
Food Card (specify amount)	**$**
Gas Card (specify amount)	**$**
Financial Aide (specify amount)	**Hard Copy of bills Attached**
Rent / Mortgage	**$** ☐
Utilities	**$** ☐
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: _____ **Cycle:** _____ **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

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

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.
