

SOUTH CENTRAL CANCER RESOURCE  
REQUEST FOR TRANSPORTATION ASSISTANCE

Name \_\_\_\_\_

Contact person \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone # for contact person \_\_\_\_\_

Age \_\_\_\_\_ Single? \_\_\_\_\_ Family? \_\_\_\_\_

How many in family? Adults? \_\_\_\_\_ Are the adults employed? \_\_\_\_\_  
Dependents? \_\_\_\_\_

Street Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Telephone #s \_\_\_\_\_

Email Address \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment needed: Type \_\_\_\_\_  
Place \_\_\_\_\_  
Duration of treatment if known \_\_\_\_\_

Are you able to arrange any of the needed rides? \_\_\_\_\_

Do you give consent for SCCR to examine your and your partner's most recent income tax Notice of Assessment in order to determine what portion of the cost of the trip that you will pay? \_\_\_\_\_

Is the Notice of Assessment an accurate indication for your current income? If not, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note that the Resource Coordinator or Board of Directors, at their discretion, may request references from the applicant.

\_\_\_\_\_  
Client signature

Application: Approved? \_\_\_\_\_ Client liability will be \_\_\_\_\_.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
SCCR signature

\_\_\_\_\_  
Date