ALLEGANY COUNTY CANCER SERVICES

We cannot help if you have Medicaid which is through the Department of Social Services, because your expenses and travel are reimbursed. If you have Medicaid and are not getting your travel expenses reimbursed, call your caseworker or the Travel Center at 1-866-271-0564.

Dear Allegany County Cancer Services (ACCS) Applicant:

Please complete the application by:

1. Completing the first page with all information
2. **Making a copy of your proof of identity and residence (current driver's license, non-driver identification, junk mail with applicant's name on it, etc.)**
3. Having your medical provider complete and sign the Verification of Diagnosis and Treatment form and return it with your application, or they can fax it.
4. Send the completed application to Lori Ballengee at the address below. Read and sign the Understanding and Release Agreement. This release allows us to contact your medical provider and to make referrals, on your behalf, to other agencies that might assist you.
5. Send the completed application to Lori Ballengee at the address below.

Please do not send anything that has your social security number on it. **All information is confidential!!**

As of our March, 2011 Board meeting, ACCS will provide a one-time financial award of $500 for any Allegany County resident that has received any kind of treatment for a cancer diagnosis. At our August, 2013 meeting, the board decided we can only assist with a cancer diagnosis that is less than two years old, and to give only gas cards. We will no longer help with co-pays, etc.

Other financial resources include Cancer Care at 1-800-813-4673 or www.cancercare.org. Please contact them for assistance.

Thank you for your interest in ACCS. Please visit our website at www.accsny.org for more information and listing of events you may want to attend.

Sincerely,

Allegany County Cancer Services Board of Directors

100 South Highland Avenue
Wellsville, New York 14895
Website: www.accsny.org

Telephone: (585)593-1569
Fax: (585)593-1569

Allegany County Cancer Services, Inc.

Client Name: _____

Date of Birth: _____

Street Address: _____

City/Town/Zip: _____

Phone Number: (_____)_____

Alternate Phone: (_____)_____

Email: _____

Where is your cancer?_____

Date of Diagnosis: _____/_____/_____
Month Day Year

How did you hear about us?_____

Do you have Medicaid? YES NO Are you a Veteran? YES NO
(For statistical use only)

_____ _____
Physician/Oncologist Name **Telephone Number**

As an Allegany County Cancer Services (ACCS) participant, you have the right:

*To be given information about referrals that can and may be made on your behalf

*To be told that standards for eligibility and participation in ACCS are the same for everyone, regardless of race, color, national origin, age, sex, disability or religious/political beliefs.

*To be assisted by staff in a timely manner for intake and services.

*To be treated with courtesy, dignity and respect at all times.

*To expect that all your records be kept confidential unless you sign a release agreeing that information may be shared for case management and better service delivery purposes.

*To be advised, in writing, if you are denied services and why.

As an ACCS participant, it is your responsibility:

*To answer all questions completely and honestly and provide all proof required that you are eligible to receive services.

*To use the services given to you only in the fashion they are intended for your cancer issues.

*To treat ACCS staff with courtesy, dignity and respect at all times. You may be given written notice and denied services if staff find you uncooperative, rude or disrespectful.

*If other services can be found to meet your needs, you accept a referral for those services.

Applicant Understanding and Release Agreement

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I hereby authorize Allegany County Cancer Services to contact the applicant's physician and obtain appropriate medical information regarding care. In addition, I consent to the exchange of information between Allegany County Cancer Services and any other organizations deemed appropriate to provide services. This consent expires upon written request from applicant/guardian OR one year from signature date, whichever comes first.

I have read and understand my rights and responsibilities and the agreement above. I declare the information furnished by me is true and complete to the best of my knowledge.

_____ _____

Applicant's Signature **Date**

_____

Print Your Name

STAPLE PROOF OF IDENTITY AND RESIDENCY HERE

Allegany County Cancer Services

In Allegany County For Allegany County

Verification of Diagnosis and Treatment

Name: _____

DOB: _____

This is to verify that the above named person has been diagnosed with

_____

(Type of cancer)

On: _____and is undergoing medical care.

(Date of Diagnosis)

Signature of Medical Provider: _____

Date Signed: _____ **USE PROVIDER STAMP HERE**

Provider Contact Information:

Please Print

Name:_____

Address:_____

_____

_____

Phone:_____

Please return this form with your application.

This information is required in order for your application to be processed.

Updated 04/16