ETHEL PRECHT Hope
BREAST CANCER PROGRAM
of WCCH
Benefitting Local Survivors

Financial Assistance Application

Calcasieu and Cameron Parish Residents Only

Receipts or copies of receipts are required along with a physician's diagnosis and/or lab sheet stating diagnosis. If receipts are not provided, application will not be processed.

PATIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____/_____/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PARISH: _____ PHONE: (_____)_____

DIAGNOSIS: _____

DATE OF CURRENT DIAGNOSIS: _____/_____/_____
(Must be within the last 5 years unless 62 and over)

HAVE YOU EVER RECEIVED ASSISTANCE FROM THIS FOUNDATION BEFORE? ____ **YES** ____ **NO**

If yes, PLEASE write the date of the previous diagnosis: _____/_____/_____

MEDICAL INFORMATION

NAME OF TREATING PHYSICIAN: _____

SIGNATURE OF TREATING PHYSICIAN: _____
(Must be signed by physician)

HOSPITAL/CLINIC: _____ PHONE: (____)_____

APPLICANT SIGNATURE _____

DATE: _____

Please Return Completed Application WITH RECEIPTS AND PATH REPORT to:

Ethel Precht Hope Breast Cancer Program of WCCH
701 Cypress Street
Sulphur, LA 70663

Email: breasthealth@wcch.com

RECEIPTS PROVIDED: _____ **DATE OF SERVICE:** _____/_____/_____

SERVICES PROVIDED: _____ **AMOUNT:** _____