Fueling Hope
Cancer Treatment Transportation Assistance Program Application
Alleghany Cares Inc.

Date of Application: _____

CLIENT NAME_____

Date of Birth_____ **Cell Phone**_____

Mailing Address_____ **Phone**_____

City_____**, NC Zip**_____ **County**_____

Emergency Contact_____**Phone**_____

Household Information

	Name	DOB	Sex	Relationship To Client
Applicant				
Spouse				
Child				
Child				
Child				
Other				
Other				

Physician Information

Primary Care Physician: _____**Phone**_____

Condition being treated_____ **Date of Diagnosis**_____

Treating Physician's Name _____ **Phone** _____

Address_____

_____

Disclosure Permission

I hereby permit the Alleghany Cares Inc. staff to contact any person or agency to discuss issues surrounding my application for assistance. I also verify that the information given above is truthful and that I have not made any attempts to misrepresent my need for assistance. I understand the Assistance Fund only reimburses for expenses related to transportation to and from treatment for my condition.

Client Signature: _____ Date_____

Staff Signature: _____Date_____

Please continue on reverse side
Transportation Assistance Program Application

Date Approved: _____

Treatment Information

Name of Treatment Facility_____

Phone_____

Address_____

_____

Number of treatment visits scheduled_____

How often? _____

Name of Treatment Facility_____

Phone_____

Address_____

_____

Number of treatment visits schedule_____

How often? _____

Name of Treatment Facility_____

Phone_____

Address_____

_____

Number of treatment visits scheduled_____

How often? _____

Please list any additional treatment facilities here_____

_____

Primary form of transportation used for visits: Personal Vehicle _____ **Alleghany in Motion**_____