



**Deary Memorial Cancer Fund  
Screening Sheet**

**DATE:** \_\_\_\_\_

**Personal information:**

**NAME:** \_\_\_\_\_  
Last First Mid. Initial Maiden

**ADDRESS:** \_\_\_\_\_  
Street Town Zip

**TELEPHONE #:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **S/S #:** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Eligibility Requirements:**

- Yes  No Resides in Northeastern Connecticut (13 towns served by Day Kimball Hospital)
- Yes  No Client is an out-patient.
- Yes  No Has a primary care physician with privileges at Day Kimball Hospital
- Yes  No Physician has determined the need for the service
- Yes  No Has no insurance **or** has co-insurance with deductible or co-payment greater than \$500
- Yes  No Maximum assistance of \$5,000 per year, renewable annually
- Yes  No Meet American Cancer Society Guidelines

<p><b>Client is eligible for Day Kimball Hospital Deary Memorial Cancer Fund</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Approved Amount: \$</b> _____</p>
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