



**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

**Client is eligible for Day Kimball Hospital
Deary Memorial Cancer Fund**

Yes No

Approved Amount: \$ _____