APPLICATION FOR CANCER ASSISTANCE

Email this form to: adminmail@oescal.org
or mail to: Grand Chapter of CA
16960 Bastanchury Rd. Ste C
Yorba Linda, CA 92886-1711

Date of Application _____

Date of Diagnosis _____

Date of Update _____

1. Name of Patient requiring aid _____ DOB _____
2. Is Patient requiring aid a member of the Order of the Eastern Star? _____
3. Address _____
   (street) (city) (zip code)

   Telephone _____ Email Address_____

4. Name of Applicant Member _____

   Relationship to Patient _____

   a. Member of _____ Chapter No. _____ Located at _____
   b. Member Number _____
   c. Length of Membership in this Chapter _____ Length of Membership in California _____
   d. Is this the first application for assistance? ❑ yes / ❑ no
5. Medical Insurance Carrier _____

   Policy Number _____ Group Number _____

   Address _____

   Telephone _____

   Medicare/Social Security Number _____
6. Applicant may be contacted on ____(date)_____ at _____(time and place)_____
7. Emergency Contact: Name _____Telephone _____

   Email Address _____

<u>This application shall be accompanied by a separate medical report by a licensed Doctor of Medicine indicating the diagnosis and the date of diagnosis.</u> All subject matter herein contained shall be considered confidential. I hereby give my permission for the Order of the Eastern Star to contact my medical care providers for information regarding my diagnosis, treatment, and account status. Questions? call Grand Chapter Office (714) 986-2380

Signature of Applicant: _____

For use by the Committees

Date Received: _____

Approved: _____ Date: _____
Cancer Assistance Chairman

Amount Approved: $_____ Fund: _____ Date Applicant Notified: _____