



Emergency Relief Referral Form For Women Coping With Cancer

Please fax completed form to:
FAX: 706.736.5142
PHONE: 706.736.5467 Toll Free 877.593.4212

Patient's First/Last Name

Home Address: Street *City* *Zip*

Telephone # *Cell or other phone #*

COUNTY of Residence *Primary Cancer diagnosis*

Attending Physician Name *Practice Name*

Physician Office Contact Person *Phone Number*

• **REQUEST IS FOR RENT OR UTILITY ASSISTANCE:** _____ Yes _____ No
Contingent on eligibility, fund assists with past due bills' total up to \$500. Patient will need to provide past due bill

• **REQUEST IS FOR HELP WITH PRESCRIPTION COSTS:** _____ Yes _____ No
Contingent on eligibility, fund assists with up to \$150 prescription costs. Script needed for Barney's Pharmacy.

• **INDIVIDUAL IS CURRENTLY RECEIVING Tx FOR CANCER:** _____ Yes _____ No

May we ask? Providing the following information helps with grant writing for funds in support of women served by The Lydia Project. Thank you! Please circle appropriate answers

African American Caucasian/White Hispanic/Latino Asian Other

Age: 18-24 25-35 36-45 46-55 56-65 66-75 76+

Physician or Healthcare Professional's Signature *Printed Name* *Date*

I understand this form is being submitted on my behalf and I request this assistance:

Patient's Signature (If patient is not at office, Lydia can secure signature) *Date*

For The Lydia Project Office Use

_____ *Date ER referral received* _____ *Date patient responded to Lydia contact call*

Lydia tote provided: ___ Yes _____ *Prayer Card #* _____ *No (tote already provided)*

1) *Amount of assistance provided* _____ *Payable to:* _____

2) *Amount of assistance provided* _____ *Payable to:* _____

For Rx: *Date info provided to Barney's Pharmacy* _____ *POC at Barney's:* _____