**Applications may be sent to:**

**Mail: Alisha Patel**

**5171 Glenwood Ave, Suite 401**

**Raleigh, NC 27612**

**Email: apatel**[**@lungcancerinitiative.org**](mailto:eedmondson@lungcancerinitiativenc.org)

**Fax: 919-784-0416**

Patient Access to Care

Gas Card Application- Returning Applicants

Name of Applicant: Date:

Address: Date of Birth:

Already received a gas card: Yes/No

Phone Number: If yes, approx. date:

|  |  |  |
| --- | --- | --- |
| 1.) Have you had any changes in your financial status? | □ Yes | □ No |
| If yes, please explain: | | |
| 2.) Have you had any changes in your working status? | □ Yes | □ No |
| If yes, please explain: |  | |

Which of the following gift cards would you prefer?

|  |  |
| --- | --- |
| BP | Exxon Mobil |
| Uber (Rideshare) |  |

If you have had any other changes since your last gas card, please explain (including treatment plan):

How has the Lung Cancer Initiative Access to Care Gas Card program impacted your life and treatment?

Name of the facility where treatment will be received:

Healthcare Facility Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person email address:

**Signature of Patient:**

**Signature of Contact from Healthcare Facility:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_