# *Allegany County Cancer Services, Inc.*

Dear Allegany County Cancer Services (ACCS) Applicant,

Our non-profit organization awards a one-time gas card for any Allegany County resident that is undergoing medical care for a cancer diagnosis. ***We cannot help if you have Medicaid*** *which is through the Department of Social Services, because your expenses and travel is reimbursed. IF you have Medicaid and are not getting your travel expenses reimbursed, please call your caseworker.*

Please complete the application per below and do not send anything that has your social security number on it. ALL INFORMATION IS CONFIDENTIAL – VERBAL AND WRITTEN.

1. Read and complete the application (Page 2) with all information. Sign the Understanding and Release Agreement which allows us to contact your medical provider and to make referrals, on your behalf, to other agencies that may assist you.

2. **Make a copy of your proof of identity and residence confirmation and send with application (ie – current driver's license, non-driver identification, utility bill with address, military ID, etc.)**

3. Your medical provider to complete and sign Verification of Diagnosis and Treatment form (Page #3) and return it with your application or fax. Diagnosis must be within two years.

4. **Send the completed application, proof of identity/address, and verification of diagnosis to:**

Allegany County Cancer Services, Inc.
P. O. Box 534
Wellsville, New York 14895
Or
email: accsny@yahoo.com

As of February 2022, our Board of Directors has approved ***a one-time $600 gas card*** for any Allegany County resident under going medical care for a cancer diagnosis. This is the only form of assistance that is given thru our non-profit organization.

Thank you for your interest in ACCS, Inc. If you have any questions, please call 585-609-7300 or email: *accsny@yahoo.com*. Please visit our website at *www.accsny.org* for more information and a listing of events you may want to attend.

Sincerely,

*Allegany County Services, Inc.*
Board of Directors

Form updated 8/29/2023

# Allegany County Cancer Services, Inc.

## Applicant Information

Full Name: _____ Date of Birth: _____

*Last* *First* *M.I.*

Address: _____

*Street Address* *Apartment/Unit #*

_____

*City* *State* *ZIP Code*

Phone: _____ Alternate Phone No: _____

Email Address: _____ Date of Diagnosis: _____

Location or Type of Cancer _____

Do you have Medicaid? YES ☐ NO ☐

## aimer and Signature

**As an Allegany County Cancer Services (ACCS) participant, you have the right:**

*-To be given information about referrals that can and may be made on your behalf.*

*-To be told the standards of eligibility and participation in ACCS are the same for everyone, regardless of race, color, national origin, age, sex, disability or religious/political beliefs.*

*-To be assisted by staff in a timely manner for intake and services. To be treated with dignity, courtesy, and respect at all times.*

*-To expect all records be kept confidential unless you sign a release agreeing that information may be shared for case management and better service delivery purposes.*

*-To be advised, in writing, if you are denied services and the stated reason for denial.*

**As an ACCS Participant, it is your responsibility:**

*-To answer all questions completely and honestly and provide all documentation as required for eligibility.*

*-To use the services given to you only as their intended use for your cancer issues.*

*-To treat ACCS, Inc. staff with courtesy and dignity at all times. You may be given written notice and denied service if staff finds you uncooperative.*

**Applicant Understanding and Release Agreement***:*

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I authorize ACCS, Inc. to contact the applicant's physician and obtain appropriate medical information to process application. In addition, I consent to the exchange of information between Allegany County Cancer Services, Inc and any other organization deemed appropriate to provide services. This consent expires upon written notification of applicant/guardian OR one year from signature date.

*I have read and understand my rights and responsibilities. I certify that my answers are true and complete to the best of my knowledge.*

Signature: _____ Date: _____

Printed Name: _____

Form updated 8/29/2023

# *Allegany County Cancer Services*

Applicant Name: _____

Date Of Birth: _____

This is to verify that the above named person has been diagnosed with

_____

(Type of Cancer)

on_____ and is undergoing medical care.
(Date of Diagnosis- **must be within 2 years)**

_____ _____
Signature of Medical Provider Date Signed

***Provider Contact Information Below:***
(Please Print)

*Use Provider Stamp Here*

Name:_____

Address: _____
*Street Address* *Room #*

_____
*City* *State* *ZIP Code*

Phone Number: _____

**Please return this form with your application.**
**Application will not be processed until completion of Information and Signatures**

**Return to:**
**Allegany County Cancer Services, Inc.**
**P. O. Box 534**
**Wellsville, NY 14895**
**Phone (585)-609-7300**
**Or**
**Email: accsny@yahoo.com**

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