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 assist you with a gas card if you have Medicaid**,*** *please contact your Social Worker for any assistance.*

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.

PLEASE CHECK BELOW ITEMS ARE COMPLETED TO AVOID A DELAY IN PROCESSING

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 (Primary care or Oncologist) to complete and sign Verification of Diagnosis form (Page #3) and return it with your application.***

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 all information to: accsny@yahoo.com

As of February 2022, our Board of Directors has approved ***a one-time $600 gas card*** for any Allegany County resident undergoing 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,

Representing:
Allegany County Services, Inc.
Board of Directors

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☐

Disclaimer 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 notifcation 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 June 28, 2024

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 of form submittal)

____ ____________________

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 All Information and Signatures
Return to:
Allegany County Cancer Services, Inc.
P. O. Box 534
Wellsville, NY 14895
Any questions: email: accsny@yahoo.com or phone 585-609-7300

Form Updated June 28, 2024