CANCER ASSOCIATION of
SPARTANBURG & CHEROKEE COUNTIES, INC.
~ Caring. Nurturing. Giving. ~

139 S. Dean St., Spartanburg, SC 29302
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Email: info@cancerassociation.org Updated 7/1/2024

HOSPICE APPLICATION FOR NUTRITIONAL SUPPLEMENTS

Date: ______________________

County of Residence: ☐ Spartanburg ☐ Cherokee ☐ ☐

First Name: ______________________ **Middle Initial:** _______ **Last Name:** __________________________

Preferred Name ____________________________ **Email** ______________________________________

Date of Birth: ________________________________ **Sex:** ☐ Male ☐ Female ☐ Other

Spouse/Significant Other: ____

Mailing Address: ____

City: ____________________________ **State** _________________________ **ZIP** __________________

Home Phone Number: __________________________ **Cell Phone Number:** __________________________

Race: ☐ Caucasian (White) ☐ African American (Black) ☐ Hispanic/Latino ☐ Asian ☐ Other ______________

Name of Hospice Group: ____________________________________ **Main Phone:** _____________________

Hospice Representative: ______________________________ **Cell Phone:** ___________________________

Representative Email: ____

On hospice care due to cancer diagnosis? ☐ Yes ☐ No

Cancer Diagnosis : ____ (date diagnosed: ______________)

Veteran in Household? ☐ **YES** ☐ **NO**

Other Assistance Requested: ☐ Wig ☐ Counseling (Patient and/or Family)

IN ORDER TO BETTER SERVE YOU, THE FOLLOWING INFORMATION MUST BE COMPLETED:

Estimated Total Household Income: ________________________ per year per month

Number Living in Household: __________

Major Medical Insurance ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ None