



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

ALL INFORMATION MUST BE COMPLETE TO PROCESS YOUR REQUEST.

Date of application: _____

Contact Information

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____
Work: _____
Email: _____

Demographics

Ethnicity (optional) _____ Race (optional): _____
Preferred language: _____
US Citizen: Yes No Green Card: Yes No

Household Information

Marital Status: Single Married Domestic Partnership Divorced
Spouse's Name: _____ Spouse's Phone: _____

Do you have children? Yes No

Child's Name: _____ Child's Age: _____
Child's Name: _____ Child's Age: _____
Child's Name: _____ Child's Age: _____
Child's Name: _____ Child's Age: _____
Child's Name: _____ Child's Age: _____

Who else lives in your home?

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Emergency Contact

Name: _____ Relationship: _____
Phone: _____



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

Current Insurance Coverage Information

- Medicare:** Part A & B, Advantage Part C, Part D
- Medi-Cal HMO:** Blue Shield Promise (BSP), Healthnet, Molina, Community Health Group (CHG), Kaiser
- Other Insurance Information including Supplemental Plans:**

Medical Information

Cancer Diagnosis: _____ Date of Diagnosis: _____

Stage of Cancer: Stage 1 Stage 2 Stage 3 Stage 4

Current Treatment: _____

Prognosis Excellent Good Fair Poor

Provider who made the prognosis

Name: _____

Address: _____

City: _____

Phone: _____

Last scheduled appt. _____ Next scheduled appt: _____

Additional Medical & Mental Health Information

Conditions/Diagnosis _____

Medications _____

Primary Care Physician/Psychiatrist

Name: _____

Address: _____

City: _____

Phone: _____

Last scheduled appt. _____ Next scheduled appt: _____



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

Employment History

Current employer: _____
Industry/Type of work _____
Salary: _____

Previous employer: _____
Industry/Type of work _____
Salary: _____
Last day worked: _____

Are you currently looking for employment? Yes No

Disability Information

Financial Information

Do you have a bank account? Yes No

Do you have multiple bank accounts? Yes No

Bank name: _____

Bank location: _____

Type of account: Savings Checking

Account balance: \$ _____

Year of most recent tax return? _____

Vehicle Information

Year: _____ Make: _____ Model: _____

Financed Leased Own



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

Additional Application Information

Yes No

Do you have family, relatives, friends, religious groups available to assist you with finances and/or basic needs? Yes No

Are you currently receiving any type of additional assistance from another person or agency. Yes No

Are you able to take public transportation (i.e., MTS, Bus, Trolley, Coaster, Medical Van, etc.)? Yes No

Do you use the transportation provided to you FREE of charge from your Medi-Cal insurance provider? Yes No

Have you applied for assistance from any Federal/State Agency (SSA, SSI, SSDI, General Relief, EBT, etc.)? Yes No

If yes, which agency? _____

Status of application: _____

Do you have an Advanced Directive on file anywhere? Yes No

Would you like information on Advanced Directives? Yes No

Do you now or have you in the past set up and received funds from a "Go Fund Me" page? Yes No

Who manages your finances: _____

Have you ever been convicted of a crime? Yes No

Date: _____

Charges: _____

Outcome: _____

Please share a reason why you are seeking assistance from Cancer Angels of San Diego

How did you hear about us?

Facebook Instagram Email Newsletter Online search

Charity event Personal referral Organization referral: _____



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

Current Monthly Income

Wages/Salary from Employer	Amount: \$ _____
Spouse/Partner	Amount: \$ _____
Property/Rental Income	Amount: \$ _____
Interest/Dividends	Amount: \$ _____
Veteran Benefits	Amount: \$ _____
Pension	Amount: \$ _____
401K/Retirement Funds	Amount: \$ _____
Roommate/Boarder	Amount: \$ _____
Other	Amount: \$ _____
<hr/>	
Total	Amount: \$ _____

Have you applied for any of the following?

(Indicate status and amount)

	Approved	Pending	Denied	Amount
Employer Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
SSA/SSI/SSDI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Other Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
EDD Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Pension/Retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Child Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Alimony/Spousal Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Foster Child Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
In-Home Care/IHSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
School Grants/Loans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
General Relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
CalWORKs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Cal Fresh – Food Stamps – EBT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____



2240 Encinitas Blvd, #D, Box 327
Encinitas, CA 92024

(760) 942-6346
info@cancerangels.org
cancerangels.org

Current Monthly Expenses

Mortgage \$ _____ /Rent \$ _____	Total Amount: \$ _____
Gas/Heat (Home)	Amount: \$ _____
Electricity (Home)	Amount: \$ _____
Water	Amount: \$ _____
Trash Collection	Amount: \$ _____
Phone: Landline \$ _____ /Cellular \$ _____	Total Amount: \$ _____
Cable TV	Amount: \$ _____
Roommate/Boarder	Amount: \$ _____
Food/Groceries	Amount: \$ _____
Auto Payment	Amount: \$ _____
Auto Insurance	Amount: \$ _____
Gas (Auto)	Amount: \$ _____
Medications	Amount: \$ _____
Medical Co-Pay/Share of Cost	Amount: \$ _____
Health Insurance Premium	Amount: \$ _____
Credit Cards	Amount: \$ _____
Other: _____	Amount: \$ _____
Other: _____	Amount: \$ _____
Other: _____	Amount: \$ _____
Total	Amount: \$ _____

Release of Information	Yes	No
Would you like to be referred to other agencies for additional assistance?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, we will need to obtain a Release of Information to share your information	<input type="checkbox"/>	<input type="checkbox"/>

By signing below, I agree the above information is accurate, true, and correct.

Signature

Date

Cancer Angels of San Diego makes every effort to process every application in a timely manner. Please feel free to reach out to us if you don't receive a response from us within (5) business days of submitting your application. We look forward to meeting you, understanding your special circumstance, and working with you to provide advocacy, assistance, and services during this very difficult and uncertain time managing Cancer.