1621 N. Taylor Drive, Suite 100 ● Sheboygan, Wisconsin 53081
920-457-2223 ● www.scccf.org

The Sheboygan County Cancer Care Fund (SCCCF) is dedicated to improving the health, well-being, and quality of life for individuals and families of Sheboygan County who have been diagnosed with cancer or a disease of the blood.

Gas Card Assistance

The SCCCF is supported entirely by public contributions. It is important that these limited funds be available for patients who are experiencing the greatest financial need. Listed below are some questions to consider before completing this application or requesting funding:

1. What impact has the diagnosis had on your current income or financial situation?
2. What unusual out-of-pocket expenses do you have as a result of the diagnosis?
3. What other financial resources do you have access to that may assist with these expenses?
   - If you have any further questions, please contact us accordingly:

Primary Cancer Treatment Facility:	Contact:	Send Application To:
Matthews Oncology Associates **Sheboygan Cancer & Blood Specialists**	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081
Aurora / Vince Lombardi Cancer Clinic	**Stephanie Struve, CSW** 920-457-4461	1222 N. 23rd St. Sheboygan, WI 53081
All Other Locations (Will need to provide written confirmation of diagnosis)	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081

Section 1: ***Person requesting assistance:***

_____ _____
Last Name, First Name, Middle Initial — Date of Birth

_____ _____
Address — Phone Number

_____ _____
City, State, Zip — Social Security Number

_____ _____
Diagnosis/Disease/Condition — Date of Diagnosis

_____ _____
Physician — Phone Number

To Be Completed By Medical Provider Representative		***To Be Completed By SCCCF Representative***	
Referred by	*Amount Requested:* $_____.00	*Amount Approved:* $_____.00	*Approved by*
	Date: _____/_____/_____	*Last 6 digits of gas card (back/top):*	

Agreement:

I certify that all information that I have presented in this written application is correct and true to the best of my knowledge. I agree that all funds received will be used for the purpose stated herein. I understand that any funds approved and provided are intended for treatment-related transportation expenses and I will be liable for any funds that are incorrectly used or that were acquired through intentional misrepresentation.

_____ _____ _____
Print Name Of Person Requesting Funds — Date — Signature of Person Requesting Funds