Rev. 11/15/2024

CONFIDENTIAL ASSESSMENT FORM

TAYLOR COUNTY GOOD SAMARITANS
P.O. Box 81, Campbellsville, KY 42719

Original application must be completed and mailed to the address listed above, along with supporting documentation for initiation of treatment.

Full Name: ______________________________ Date: ______________

Nickname: __________________ Gender M F (circle one)

Name of Spouse: __________________________ County of Residence: __________

Mailing Address: ____
(Street or P.O. Box)
____
(City, State, Zip Code)

Email: ____________________________ Phone: ______________________

Alternate Phone: ____________________ Dependents (with ages): ______________
____

Has there been any loss of income or additional expenses in the household related to your treatment? Please explain or add any information you would like for us to take into consideration.
____
____

Diagnosis (type of cancer): ______________________ Date of Diagnosis: _________

Date of most recent treatment: __________________

Current and/or expected course of treatment (please explain): ______________________
____
____

Chemotherapy: _____ Immunotherapy: _______ Radiation: ______ Surgery: __________

Expected duration of treatment: ____

Additional comments/extenuating circumstances: ______________________________
____

I acknowledge the information on this application to be true and accurate to the best of my knowledge and belief.

Applicant Signature: ______________________________ Date: _____________

*Attach additional page or use back of the form, if needed. *All checks issued to award recipients become voided after 6 months.