



Please complete and sign this form and return it using the self-addressed envelope. Your eligibility for this program cannot be determined unless your application is signed and all documents requested are attached.

Delaware Cancer Treatment Program  
 Division of Public Health  
 C/O EDS  
 P.O. Box 950 Manor Branch  
 New Castle, DE 19720-0950

**1. Applicant Information**

First Name	MI	Last Name	Social Security Number*	Marital Status	Household Size
			- -	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Separated	

\* Social Security Number is optional, however, providing it will help facilitate processing your application.

Residence Street Address (cannot be a P.O. Box)	Apt. No.	City	Zip	County	Phone Number
Mailing Address (if different from above)	Apt. No.	City	Zip	County	Phone Number

<b>Ethnicity</b>	<b>Race</b>	<b>Gender</b>	<b>Date of Birth</b>	<b>Do you have Health Insurance?</b>
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Alaskan <input type="checkbox"/> Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Other	<input type="checkbox"/> Female <input type="checkbox"/> Male	/ / MM / DD / YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Plan Name  Plan Phone Number

What is the date of your cancer diagnosis?    MM / DD / YYYY

On the date of your cancer diagnosis, where was your primary residence? (State only) \_\_\_\_\_

**2. Income Information**

**Documentation (or proof) must be provided with this application. Please send photocopies only, not original documents.**  
 You, your spouse's and other household members' income must be reported. Earnings, interest on savings and/or investments, Social Security, Veteran Benefit, cash given to you and any other income must be reported.

Attach a separate sheet for additional space.

Source of Income	How often	Amount (after taxes/deductions)

**Rights and Responsibilities**

I have read or have had read to me all of the statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.  
 I understand that all the information I give is confidential and federal and state laws limit disclosure of information about me.  
 I understand and agree to give proof of my statements. I understand that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

\_\_\_\_\_  
 Signature of Applicant or Representative

\_\_\_\_\_  
 Date

If representative, please print name, relationship and phone number

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Phone