UNITED WE CARE UNITED WE SHARE

UNITED CANCER SUPPORT FOUNDATION

6700 Baum Drive Suite 8 Knoxville, TN 37919 www.UnitedCSF.org P. (865)-474-1551 E. info@unitedcsf.org

"Recliners for Recovery" Program Application Information

Please Note: The recliners are only available in the KNOXVILLE, TN area as they are for office pick up ONLY.

Dear Cancer Patient,

United Cancer Support Foundation is a 501(c)3 nonprofit organization. One of our support initiatives is **Recliners for Recovery.** It is designed to support cancer patients with comfort during this challenging time. The recliner can help the patient relax, as well as provide improved blood circulation in the legs, alleviate back pain and problems with nausea.

To complete the application process:

- Fill out our **Application Form** and **Memorandum of Understanding**.
- Mail the form to: **Patient Support Department, 6700 Baum Drive Suite 8 Knoxville, TN 37919** or send email attachment to: info@UnitedCSF.org.
- Once we have received the completed forms, we will process and verify the information in the forms.
- We will contact you to schedule a pick up date and time when a chair is available.

Sincerely,

Patient Support Department

United Cancer Support Foundation

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"RECLINERS FOR RECOVERY" PROGRAM APPLICATION

PATIENT INFORMATION		
Patient's First name:	Middle:	Last name:
Birth date: _____/_____/_____	Age:	Gender: ☐Male ☐Female
Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Latin American ☐ Asian ☐ Other		
Home address:		
City:	State:	ZIP code:
Phone No.:	E-mail:	
How did you hear about our program? ☐ Family / Friend ☐ Online Research ☐ Callers ☐ Other (specify):		
Household size:	Household income: ☐ under 20k ☐ 20k to 49,999 ☐ 50k to 74,999 ☐ 75k to 99,999 ☐ over 100k	

MEDICAL VERIFICATION		
THIS PORTION MUST BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY		
Medical Professional:	Title:	
Office address:		
City:	State:	ZIP code:
Phone No.:	E-mail:	
Year diagnosed?	**Cancer type and stage:**	**Is cancer in remission?** ☐ Yes ☐ No
Current treatment status: ☐ Chemotherapy ☐ Surgery ☐ Radiation ☐ Other(specify):		
Comments:		

X _____ _____

Medical Professional's Signature* **Date (mm/dd/yyyy)**

*Under penalty of perjury, I declare that I have examined this form, including any accompanying statements and schedules, to the best of my knowledge; it is true, correct, and complete.

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EMERGENCY CONTACT PERSON OR GUARDIAN (OPTIONAL)	
Contact Name (first, last):	Relationship to patient:
Home phone:	Work phone:

Please describe why you are applying for this program and how it will help you?

_____

_____

_____

_____

_____

_____

Terms of Agreement

1. I hereby declare that the information provided in this form is true and correct.

2. I understand that this program is only supporting the cancer patients who are currently undergoing treatment.

3. I understand that all information submitted will be kept strictly confidential and to be used for statistical analysis and education purposes only.

4. I understand that UCSF will reserve the right for final decision of the application and to decline application without providing any explanation.

5. I understand that this program is provided based on availability and eligibility.

*By Signing my name below, I acknowledge that I have read, understand, and agree to the policies listed above

Patient's Signature: _____ Date: _____