Wings
Regional Cancer Support

APPLICATION FOR BENEFITS

Wings is set up to help cancer patients, who are having a financial hardship. Our funds are limited. Please DO NOT apply, if you do not fit this criteria.

Name: _____ Date: _____

Address: _____ City: _____ State _____ Zip: _____

Telephone: _____ Age: _____ DOB: _____ SS #: _____

Contact person: _____

Brief description of illness and treatment: _____

_____

_____

Dates of medical services: _____

Local Physician: _____ Phone: _____

Attending Physician: _____ Phone: _____

Travel from: _____ to: _____

Trips: _____ Round trip mileage: _____

Lodging per night: _____ # of nights: _____

# of meals eaten: _____

Please send in receipts from hotels, airplane tickets, and meals for reimbursement.

Do you have insurance? _____ Medicaid? _____ (Medicaid may pay for transportation, housing or meals)

Insurance Company: _____

Have you received Wings funding before? _____ If yes, for what amount: _____ Year received? _____

The American Cancer Society may be able to help with lodging/transportation. Have you applied for assistance?

I hereby state that the above information is correct and that there are no other sources of funding for the expenses for which I am requesting reimbursement. I also consent to the release of medical information from my primary physician or hospital regarding my cancer. This information will be used solely for the determination of Wings benefits.

Date: _____ Signature: _____

Return application to: Wings
PO Box 7852 • Kalispell, MT 59904
406-257-WING (9464)

The Wings Allocations Committee meets the second week of each month to review applications. Reimbursement checks are typically mailed by the 15th of each month. Depending on the timing, it may take 6-8 weeks for applications to be processed and funds distributed.

OFFICE USE ONLY

Approved _____ Disapproved _____

Comments: _____

Check # _____ Check amount _____ Date _____