Cancer Council SA

Financial Services Program
Referral Form

This application form is to be completed by a Health Professional. Refer to Cancer Council SA Financial Services Program guidelines for more information. Please scan and send via email to financialassistance@cancersa.org.au. For enquiries, please contact **Cancer Council 13 11 20**.

REFERRER DETAILS	
Name of Referrer:	Position:
Email:	Phone:
Hospital/Agency:	Referral date:

CLIENT INFORMATION (person with cancer)		
Name:	Date of birth:	
Address:		
Suburb:	State:	Postcode:
Email:		
Phone:		
Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say		
Aboriginal and/or Torres Strait Islander? ☐ Yes ☐ No CALD background? ☐ Yes ☐ No Specify: _____ Language: _____ Interpreter required? ☐ Yes ☐ No Carer/legal guardian/other contact details: _____		

MEDICAL DETAILS	
Cancer type:	Date of diagnosis (if known):
Cancer stage: ☐ Early/localised ☐ Metastasis/widespread/advanced ☐ Recurrence ☐ Terminal ☐ Other _____	

PSYCHOSOCIAL ASSESSMENT
Living situation: ☐ Alone ☐ With partner ☐ With dependants
Number and age of dependant children: _____
Other comments: _____
_____

FINANCIAL SITUATION *(tick all that apply)*

INCOME

Employment status pre-diagnosis			Current employment status		
Client	**Partner**		**Client**	**Partner**	
		Full-time			No change
		Part-time			Reduced hours
		Not working			Not working
		Centrelink			Applying for benefits/pension
		Permanent			Paid leave
		Casual			Unpaid leave
		Other			Other

EXPENSES

Specify any increase in expenses as a result of cancer diagnosis (e.g. treatment related costs, increase in household utility costs, etc): _____

_____

_____

_____

_____

_____

BILL FOR PAYMENT — AMOUNT: $

- ☐ Ambulance Membership
- ☐ Car Registration
- ☐ Council Rates
- ☐ Electricity
- ☐ Emergency Services Levy
- ☐ Gas
- ☐ Phone/Internet
- ☐ Water Rates

- ☐ I confirm I am submitting this form on behalf of a person with cancer who, following my assessment and in my professional judgement requires financial assistance due to the impact of their cancer diagnosis.
- ☐ I confirm the client is aware of and has consented to the use of their personal information for the purpose of Cancer Council SA processing this Financial Services Program referral.
- ☐ I have attached a copy of the client's bill.

Signature of Referrer: Date:

Collection Statement

Your privacy is as important to Cancer Council SA as it is to you. That's why any personal information you give us will be treated with respect and in strict confidence. Personal information is collected to assess and process your application. Your Personal information may also have been collected to process donations, issue tax receipts and to send you updates. We may disclose your information to agents, contractors and third parties who provide services to us, and in doing so we take reasonable steps to ensure any information held by our service providers is protected. A full copy of our Privacy Policy is at www.cancersa.org.au/privacy with details about how you can access and correct your personal information and how we handle any privacy complaints. Or call us on 1300 65 65 85 for more details about our commitment to your privacy.

☐