

PART A. Health Professional/Requester Information

**Mandatory fields*

*Health professional name: _____

*Hospital/treatment centre: _____ Occupation/role: _____

*Phone number: _____ (and *pager): _____

*Email: _____

Is this request priority? No Yes *If yes, please state reason:* _____

Client has given consent to be contacted by Cancer Council NSW regarding the assistance detailed on this form.

I have read and confirm the client has been informed of the following privacy statement. Yes No

Cancer Council NSW values your privacy. Cancer Council NSW is collecting the information on this form for the purpose of referring the client to our services. By completing this form you undertake that you and all third parties on whose behalf you are completing this form, consent to that information being used by Cancer Council NSW and being shared with third-party service providers for that purpose. Cancer Council NSW will handle all Personal Information provided on this form in accordance with the Privacy Act 1988 (Cth) and its Privacy Policy. If you have any queries relating to the Cancer Council NSW's Privacy Policy or the manner in which we handle your personal information, please contact our Privacy Officer on (02) 9334 1417 or privacy@nswcc.org.au.

PART B. Patient Information

**Mandatory fields*

Title: _____ *First name: _____ *Surname: _____

Preferred name: _____

*Date of birth: _____ / _____ / _____

Email: _____

*Phone number: Home: _____ Mobile: _____

Is it ok to leave a voice message? Yes No

*Home street address: _____ Suburb: _____ Postcode: _____

Postal (if different to home): _____ Suburb: _____ Postcode: _____

Gender identity:

Female Male Transgender Female Transgender Male
 Non-Binary Other Prefer not to say

*Aboriginal and/or Torres Strait Islander origin?

Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander No, neither

*Main language spoken at home: _____ *Interpreter needed? Yes No



PLEASE REFER TO ELIGIBILITY CRITERIA (Part D. of this form) BEFORE COMPLETING THIS PAGE

PART C. Types Of Support Available

**Mandatory fields*

Emotional Support Services

13 11 20 Information & Support

- Client would like to discuss a cancer-related concern with a health professional.
- Client would like information on our resources (e.g. webinars, podcasts and publications).

Cancer Connect

- *I confirm that the client meets the eligibility criteria.

Counselling

If requesting subsidy, please complete the financial assessment – see Part D.

- *I confirm that the client meets the financial assessment eligibility criteria.

Can the client travel to an appointment? Yes No

- *I confirm that the client meets the eligibility criteria.

Telephone Support Groups

- *I confirm that the client meets the eligibility criteria.

Practical Support Services

Accommodation Hardship

Please complete the financial assessment – see Part D.

- *I confirm that the client meets the eligibility criteria.

Dates of accommodation: Check in: ____/____/____ Check out: ____/____/____

Please tick if the patient requires:

- Lift access Twin share Easy access (wheelchair friendly room)

ENRICHing Survivorship

- *I confirm that the client meets the eligibility criteria.

Financial Counselling

- *I confirm that the client meets the eligibility criteria.

Home Help Payment Assistance

- *I confirm that the client meets the eligibility criteria.
- Please tick if you have attached an invoice for payment.



Cancer Support Request Form

Complete this form to apply for emotional and/or practical support.

Practical Support Services

Financial Assistance

*I confirm that the client meets the eligibility criteria.

*Type of financial assistance required? (Can select multiple options up to a total of \$350)

Assistance with utility or other bill Amount (\$) _____
(please attach invoice for payment)

Grocery (Coles) vouchers Amount (\$) _____ Digital or Physical vouchers
(Please note, digital vouchers are \$350 only and will be emailed to the client. Please provide client's email address in Part B)

Fuel (BP) vouchers Amount (\$) _____

CabCharge vouchers Amount (\$) _____

Other _____

Please tick if you have attached an invoice for payment.

Pro Bono Program

*I confirm that the client meets the eligibility criteria.

*I have advised the client that the service is means-tested.

What does the client need help with? _____

Can the client travel to an appointment?

Yes No If no, needs to be seen at: home or hospital

Transport to Treatment (T2T)

*I confirm that the client meets the eligibility criteria.

To request transport support for your client, please complete the booking form at cancercouncil.com.au/booktransport



Cancer Support Request Form

Complete this form to apply for emotional and/or practical support.

PART D. Financial eligibility: Financial Assistance, Home Help Payment Assistance, Accommodation hardship & Counselling (100% subsidy only)

*Mandatory fields

These hardship services aim to support people affected by cancer experiencing acute financial hardship. Acute financial hardship indicators include but are not limited to: where the client is unable to afford their everyday expenses; they have experienced a reduction in income or are unable to work; they are experiencing an increase in expenses and associated debts. Please see the list below for a guide to the financial eligibility criteria for these services. If you feel that your client is in financial hardship but does not fall within the below financial eligibility criteria or exceptional circumstances should be applied, please phone us to discuss their specific circumstances, or provide additional information in relation to their acute financial hardship on the Request Form.

Clients will be financially eligible for the services in the following circumstances:

- client receives a Centrelink payment; OR
- client has been approved for Centrelink payments but is waiting on payments; OR
- client resides in Department of Housing; OR
- client receives less than \$45,000 gross per year, or if the client has a partner/spouse, their combined income is less than \$67,000 gross per year. Please note that if the client has financially dependent children, an additional \$13,000 allowance per child is applied; AND
- client does not have an investment property.

Eligibility for cancer counselling subsidy:

- above would apply to 100% subsidy only;

If the health professional does not have the financial information of the client on hand, we will phone the client to assess their eligibility for the counselling subsidy.

*Is the client receiving Centrelink payments?

Yes No Pending – approved but waiting

(If yes) What type of payment is client receiving? (tick all that apply)

JobSeeker Payment Disability Support Pension Aged Pension
 Carer Payment Carer Allowance Mobility Allowance
 Parenting Payment Family Tax Benefit Low Income Health Care Card

Client's living situation

Owner occupied Private Rental D.O.H Other: _____

*Do they own an investment property? Yes No



Cancer Support Request Form

Complete this form to apply for emotional and/or practical support.

What's the client's employment status?

Unemployed Casual Part time Full time Retired

Is the client single and earning less than \$45,000? Yes No

Is the client partnered and earning a combined income of less than \$67,000? Yes No

Does the client have any financial dependents? Yes (if yes how many _____) No

*Please provide any additional details of the client's financial situation:

**I am satisfied this client is experiencing significant financial hardship* Yes No

Thank you for completing this request form – we will contact the client as soon as possible. If you have any questions, please contact 131120 Information and Support, Monday to Friday 9am-5pm.

