The Sheboygan County Cancer Care Fund (SCCCF) is dedicated to improving the health, well-being, and quality of life for individuals and families of Sheboygan County who have been diagnosed with cancer or a disease of the blood.

1621 N. Taylor Drive, Suite 100
Sheboygan, Wisconsin 53081
920-457-2223 ● www.scccf.org

Request for Gas Card

The SCCCF is supported entirely by public contributions. It is important that these limited funds be available for patients who are experiencing the greatest financial need. Listed below are some questions to consider before completing this application or requesting funding or assistance:

1. What impact has the diagnosis had on your current income or financial situation?
2. What unusual out-of-pocket expenses do you have as a result of the diagnosis?
3. What other financial resources do you have access to that may assist with these expenses?

Primary Cancer Treatment Facility:	Contact:	Send Application To:
Matthews Oncology Associates **Sheboygan Cancer & Blood Specialists**	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081
Aurora / Vince Lombardi Cancer Clinic	**Stephanie Struve, CSW** 920-457-4461	1222 N. 23rd St. Sheboygan, WI 53081
All Other Locations (Will need to provide written confirmation of diagnosis)	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081

Person (cancer patient/survivor) in need of or requesting assistance:

_____ _____
Last Name, First Name, Middle Initial — Date of Birth

_____ _____
Address — Primary Phone

_____ _____
City, State, Zip — Last 4 Digits of SSN

_____ _____
Diagnosis/Disease/Condition — Date of Diagnosis

_____ _____
E-mail Address — Alternate Phone/Cell

_____ _____
Physician — Phone Number

Gas Card Request	Amount Requested: (In Town) (Out of Town) ☐ $25 ☐ $50 Fuel Only Cards Can Be Redeemed at Kwik Trip	**For SCCCF Use Only: Approved ☐ Yes ☐ No** **Date: ____/____/____ ☐ $25 ☐ $50** **Authorizing Signature(s):** Gas Card Number (last six digits):

Agreement (to be signed by the individual listed on Section 1 of this application): I certify that all information that I have presented in this written Request for Gas Card is correct and true to the best of my knowledge. I agree that all funds received will be used for their stated purpose. I understand that any funds approved and provided are intended for treatment-related transportation expenses and I will be liable for any funds that are incorrectly used or that were acquired through intentional misrepresentation.

_____ _____
Signature of individual listed on Section1 (required-unless waived by SCCCF) — Date

_____ _____ _____
Name of Person Completing Application (if other than individual listed on Section 1) — Relationship — Signature of Person Completing Application