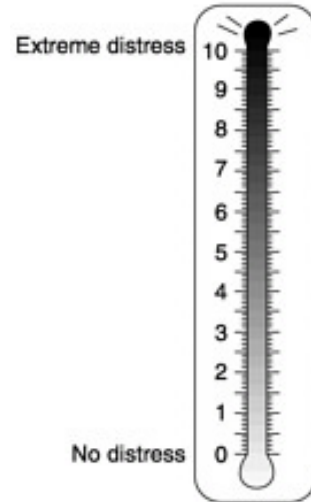


**Cancer Foundation of Northeast Georgia  
Financial Distress Screening**

**First please circle the number on the scale to the right that best describes how much financial distress you have been experiencing in the past week including today.**



**Second please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.**

- | <b>YES</b>               | <b>NO</b>                | <b><u>Financial Problems</u></b>                     |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prescription coverage/copayments                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Past due utilities                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Past due rent/mortgage                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Insurance premiums                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Insurance copayments                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutritional assistance                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Durable Medical Equipment (not covered by insurance) |
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation costs                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____   |
-