BOONE COUNTY CANCER SOCIETY

AWARENESS. SERVICE. EDUCATION.

117 West Elm Street, Lebanon, IN 46052
Phone: 765-482-2043 **Fax**: 765-481-2262
Email: boonecancersociety@gmail.com
Web: www.boonecountycancersociety.org

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Information **(please print clearly)**

First name: _____ Last name: _____ Today's Date: _____

Address: _____ City, State and Zip: _____

Phone number: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ Email Address: _____

Date of Birth: _____ If patient is a minor (under 18) name of parent or guardian: _____

Sex: ____ Male ____Female Ethnicity: ____White ____African American ____Latino _____Asian ____Other

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Medical Information
*****THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL PATIENT NAVIGATOR ONLY**

Date of Diagnosis: _____ Primary Cancer: _____ Current Stage: _____

_____New diagnosis _____Recurrence **Is the patient in current treatment?** _____Yes _____No

If not in active treatment, please indicate the frequency of follow up: ____Yearly ____Every six months ____Other

Please indicate type of treatment(s) received in past twelve months (check all that apply):
___Chemotherapy ___Radiation ___Surgery ___Hormonal ___Palliative Care ___Bone Marrow/Stem Cell Transplant

*****Please complete all fields above*****

MD name: _____ Hospital/Clinic: _____

Address: _____ City, State and Zip: _____

Phone: (_____) _____ Email: _____

Name & title of person completing this section, if different than above (please print): _____

Phone: (_____) _____ Email: _____

Your relationship to person applying for help: ____Doctor ____Nurse ____Social Worker _____ACH Hospital Patient Navigator

Signature of MEDICAL Professional: _____

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED

PATIENT'S NAME: _____ DOB: _____

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE

HEALTH INSURANCE INFORMATION

Does the patient have health insurance: _____ Yes _____No

If yes, please indicate the type of insurance (check all that applies):

____Private insurance ___Medicaid ____Medicare ____Medicare plus Medigap ____Charity care ____VA program

Are prescription drugs covered? _____Yes _____No

HOUSEHOLD FINANCIAL INFORMATION

Is the patient currently employed? _____Yes _____No Number of people in household: _____

FAMILY INCOME SOURCES (please check all that apply)

_____Social Security (Retirement) _____Salary _____Pension _____Unemployment
_____Short Term Disability _____ Public Assistance _____SSI _____SSD (Disability)
_____Family/family provide support _____Other – please specify _____

*****Application will not be processed if this information is not provided*****

Please be aware that funds are limited and based on availability as well as on meeting Boone County Cancer Society's eligibility requirements. Our assistance is NOT for living expenses such as rent, mortgages, utility payments, or food. If you need this type of assistance, we will be happy to refer you to a local agency for help.

FINANCIAL ASSISTANCE NEEDS (check all that apply):
I need your help with the following cancer-related expenses:

Name of person completing this section (please print): _____

_____Transportation _____Cancer-related mediations _____Pain medications _____Wigs/Prosthetics

_____Lymphedema Supplies (Breast Cancer) _____Co-pays _____Mammogram Assistance

Signature: _____ Date: _____

Relationship to the person applying for help: _____Self _____Spouse _____Family Member/Caregiver _____Health Care Professional

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Thank you.
Fax this form to: (765)481-2262 or
Mail to: 117 West Elm Street Lebanon, IN 46052
Boone County Cancer Society will review this information and contact the person requesting financial assistance.
ALL information is strictly confidential and is for Boone County Cancer Society's use only.

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AUTHORIZATION FOR CANCER RELATED MEDICAL SUPPLIES

DATE: _____ CLIENT: _____ DOB: _____

_____ I give the above names client/patient permission to get supplies and/or medication regarding their Cancer. (**Please notify the Cancer Society for availability of funds).**

_____ Please discontinue permission for the above names client/patient to receive supplies and/or medications.

Signature of BCCS Representative

Parkside/Cowan Pharmacy
1639 N. Lebanon Street
Lebanon, IN 46052
Phone: 765-482-1600
Fax: 765-482-4561

Kroger Pharmacy
2420 N Lebanon Street
Lebanon, IN 46052
Phone: 765-482-7095
Fax: 765-482-7480

Marsha's Wigs
716 E 65th Street
Indianapolis, IN 46223
Phone: 317-253-1119
Cell: 317-466-1572

Wigs We Care
850 N Madison Ave
Greenwood, IN 46143
Phone: 317-889-1635

Women's Pavilion Boutique
Witham Health Services
2705 N Lebanon Street
Suite 100 inside North Pavilion
Lebanon, IN 46052
Phone: 765-482-8432
Fax: 765-485-8433

Designer Cuts
1655 N Lebanon Street
Lebanon, IN 46052
Phone: 765-482-0109

HIPAA (Health Insurance Portability and Accountability Act of 1996)
Authorization for Use or Disclosure of Information
For Purposes requested by Boone County Cancer Society

I, _____, hereby authorize the Boone County Cancer Society to:

1. Access my personal medical records from my physician(s) and authorize the Boone County Cancer Society to receive copies of those records
2. Use the following protected health information and/or
3. Disclose the following protected health information from the Boone County Cancer Society

This protected health information is being used for the following purposes:

1. Patient's demographic information, required by the Boone County Cancer Society, to contact the patient and perform evaluation.
2. Gather required documents for billing purposes.

This authorization shall be in force and in effect until the event that related to the patient of the purpose of disclosure of this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Attn: Boone County Cancer Society. I understand that a revocation is not effective to the extent that the Boone County Cancer Society has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law or state to the extent the state law provides greater access rights.
- Refuse to sign this Authorization.

The Boone County Cancer Society will not condition my treatment on whether I provide authorization for the requested use or disclosure, except for the following circumstances:

- When the provision of health care by the Boone County Cancer Society is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Boone County Cancer Society from a third party (if applicable).

_____ _____
Signature of Patient Date

_____
Printed name of Patient