

**117 West Elm Street, Lebanon, IN 46052**

**Phone**: 765-482-2043 **Fax**: 765-481-2262

**Email**: [boonecancersociety@gmail.com](mailto:boonecancersociety@gmail.com)

**Web**: [www.boonecountycancersociety.org](http://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

**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

**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