Application for Assistance

Application Instructions and Checklist

Thank you for sharing with us. We're glad you're giving us an opportunity to help you and your loved ones in your diagnosis.

We determine eligibility based on current need and funding available. You will be notified as soon as possible to the status of your application. Once you've been approved, we'll determine the amount and nature of your grant. Please send inquiries pertaining your application to info@cancercopayrelief.

In completing this application you will need to have the following information ready:

- Information about your diagnosis
- Insurance policy information and a photocopy of your card (front and back)
- Income information and a photocopy of your most recent taxes
- Physician / Pharmacy / Infusion Therapy addresses and telephone numbers
- Estimated monthly cost of your copayments including office visits, medications, etc.

Please deliver the Physician Verification form to your oncologist and have their office mail it directly to us.

When you complete this application please attach the following and mail your completed application to:

Cancer Copay Relief
2275 Smith Avenue SW
Marietta, GA 30064

- A clear photocopy of your most recent insurance cards (front and back). If the information is difficult to read, please write it legibly on the photocopy
- A copy of your most recent taxes verifying all income sources.
- A written statement describing your current situation. We find that facts and figures only account for a portion of the human condition. Let us know what's going on in your life.

Application for Assistance

www.cancercopayrelief.org

Step 1. Patient Information

First Name ______________________ Last Name ____________________________

Gender: ○ Male ○ Female Date of Birth ___________________________

Mailing Address: ____

City __________________________ State _____________ Zip _____________

Phone ( ) ______-___________ Email Address _________________________

US Veteran ○ Yes ○ No (If yes, do you have medical/prescription coverage through the VA?)

Disabled ○ Yes ○ No Spouse ○ Yes ○ No

Type of Cancer ________________________ Diagnosis Date ______________

Stage ________________________________ ICD-9 Code (if known) ___________

Number of Dependents in your household (you, spouse, child = 3) ________________

Patient Advocate Helping You (if applicable)

First Name ______________________ Last Name ____________________________

Mailing Address: ____

City __________________________ State _____________ Zip _____________

Phone ( ) ______-___________ Fax ( ) ______-___________

Step 3. Insurance Information

Primary Insurance

Insurance Company ____

Address ____

City ________________________ State ____________ Zip ____________

Phone ( ) _____-__________ Fax ( ) _____-__________

Subscriber ID _________________________ Group Number ____________

Subscriber Name ______________________ Effective Date ____________

If this is a COBRA, when does it end ____/ ____/ ____

Secondary Insurance

Insurance Company ____

Address ____

City ________________________ State ____________ Zip ____________

Phone ( ) _____-__________ Fax ( ) _____-__________

Subscriber ID _________________________ Group Number ____________

Subscriber Name ______________________ Effective Date ____________

If this is a COBRA, when does it end ____/ ____/ ____

Note: You are asked to submit a photocopy of the front and back sides of all insurance cards. Please make sure that all identification and phone numbers are legible, and that all information is correct, and current.

	Primary	Secondary
What is your annual deductible? The amount you pay before insurance begins coverage.		
What is your Out of Pocket Maximum? The total amount before insurance pays at 100%		
What is your annual maximum? The maximum amount insurance will pay in a calendar year, after which you are responsible for 100% of debt incurred.		
What is your prescription copayment? Pre-determined amount you pay for each prescription.		
What is your office copayment? Pre-determined amount you pay for each office visit.		
Co-insurance percentage		

Medicare Part D (if applicable): Standard Prescription Drug Plan

How much of your $250 deductible have you met? ___________

How much of your Out-of-Pocket have you paid toward your Medicare Part D Coverage Gap? ___________

If you are unsure of this information ask your pharmacist for a printout of your Out-of-Pocket expenses paid to date.

Please provide your current yearly income	You	Spouse
Gross Salary (pre-tax)		
Unemployment Income		
Social Security / Disability		
Pension		
Annuity		
Alimony / Child Support		
Income Assistance (government)		
Other income		

Note: You are asked to submit financial documentation. Please make sure that the information is current, legible, and complete.

Prescribing Physician Information

First Name ______________________ Last Name ____________________________

Mailing Address: ____

City __________________________ State _____________ Zip _____________

Phone ( ) ______-____________ Fax ( ) ______-____________

Pharmacy

Pharmacy Name ____

Contact _________________________________ Position ____________________

Mailing Address: ____

City __________________________ State _____________ Zip _____________

Phone ( ) ______-____________ Fax ( ) ______-____________

Infusion Provider (if applicable)

Infusion Provider Name ______________________________

Contact ______________________ Position ______________

Mailing Address: ______________________________

City ______________ State ________ Zip ________

Phone ( ) ___-______ Fax ( ) ___-______

Your Medication and Copayment Costs

Please list all the copayments you make in a month, and their costs. Attach additional sheets of paper to the back of the application if needed.

Item name (office visit, medication etc)	How long will this be needed, and how often?	Estimated Monthly Cost

Is there another cost weighing heavily on you at this time? Please explain. Feel free to add additional sheets of paper to the back of the application if needed.

Patient Consent

I certify that:

- I am legally able to sign this application
- The information provided is accurate and complete
- I am not receiving assistance from another organization to pay for my copayments
- I will contact Cancer Copay Relief should my insurance status, doctor, pharmacy, and/or infusion therapy provider information change

I hereby allow Cancer Copay Relief to:

- Verify the information in this and subsequent applications to make sure it is complete and true.
- Share my information with those helping Cancer Copay Relief.
- Contact me by mail, phone, or email about Cancer Copay Relief, and/or other programs that might serve me.
- Share my information with the pharmacy that may supply my medicine, and also the physician that prescribed my medicine.
- Share my information with my doctor's office.

I understand that Cancer Copay Relief will only use my information to:

- Assess whether or not I qualify for the program.
- Assist the work-flow of the foundation
- Communicate with insurance plans, and/or other medical offices.

I further understand that:

- Cancer Copay Relief is not in any way liable for my cancer treatment; it's successes, failures, accuracies, or any harm done to me by the treatment.
- Cancer Copay Relief may ask me for further information at any time.
- Assistance may change or stop at any time, for any reason with or without notice.
- If I am found to have falsified information, leading toward financial assistance, I may be found liable for the cash amount granted, and will have to refund it to Cancer Copay Relief.
- I can withdraw from the foundation at anytime by sending my request in writing to: accounts@cancercopayrelief.org

If this form was completed by an advocate, I also grant permission for Cancer Copay Relief to contact them to further help my application.

Signature of Applicant

X ____________________________________ Date ______________________

Cancer Copay Relief

Physician Verification Form

Greetings. Your patient is applying for assistance from Cancer Copay Relief, a non-profit organization which gives financial assistance to cancer patients currently receiving treatment for their illness. If you have any questions, please send them to info@cancercopayrelief.org or visit our website at www.cancercopayrelief.org

Please complete this form, and mail it to:

Cancer Copay Relief
2275 Smith Avenue SW
Marietta, GA 30064

Patient Information

First Name ________________________ Last Name ______________________________

Gender: ○ Male ○ Female Date of Birth _____________________________

Mailing Address: ____

City ____________________________ State ______________ Zip ______________

Phone ( ) ______-____________ Email Address ___________________________

Type of Cancer _______________________________ Diagnosis Date ______________

Stage ___________________________________ ICD-9 Code ____________________

Prescribing Physician Information

First Name ________________________ Last Name ______________________________

Tax ID# ___________________ License # ____________________ DEA# ___________

Mailing Address: ____ Suite _______________

City ____________________________ State ______________ Zip ______________

Phone ( ) ______-____________ Fax ( ) ______-____________

Contact Person ____________________________________ Position _______________

email ______________________________

Medications that are currently, prescribed or foreseeable in the near future for treatment associated with your patient's cancer diagnosis:

Medication	**Frequency**	**Expected length of treatment**

Other copayments associated with your office's care of your patient (office visits, in-office treatments, etc)

Medication	**Amount**	**Frequency**

I understand that Cancer Copay Relief grants financial assistance to patients based on current need and availability of funding. I verify that the information contained on this form is accurate and complete. I also certify that the medications have been, or will be prescribed and that I will be overseeing this patient's treatment.

Physician's Name ____

Physician's Signature ____________________________ Date_____________