BREAST CANCER FOUNDATION OF THE OZARKS
APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or on going consequences of treatment related to breast cancer. Application for assistance will be individually evaluated by our organization after completion of this form and verification from your health care provider concerning your breast cancer status. Please fill this form out completely.

Name	D.O.B	SSN
Address	City	Zip
Telephone	Email	County
Spouse	Children at home and ages	Other Dependents

Medical Diagnosis
_____
_____

Physician	**Health Coverage** ____No ____Yes If yes, Circle TYPE Personal Policy Through Employer Medicare Medicaid What is your deductible?_____ Is your premium deducted from your paycheck? Yes No If yes, how much per month_____

Please state what payments we can help you the most with:
_____
_____
Other Agencies you are currently working with
_____
Employer (if applicable)
_____

BCFO pays to invoice only, cash is not provided.

Amount Requested: _____ (BCFO does not pay medical, phone, cable, pharmacy bills or credit cards.)

Enclosed is a medical records release form you will need to fill out so that BCFO can receive information verifying your breast cancer status. I hereby certify that I have been diagnosed with breast cancer and require financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

Date:_____ _____
Patient/Family Member/Other

PLEASE RETURN TO: 620 W. Republic Rd. Ste. 107 | Springfield, MO 65807

BREAST CANCER FOUNDATION OF THE OZARKS
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CALL: 417-862-3838 for help with questions

Financial Information

Income

Employment	Patient	_____
	Spouse	_____
	Other	_____
Retirement	Social Security	_____
	VA Pension	_____
	Employee Pension	_____
Other Income	Alimony	_____
	Child Support	_____
	Investments	_____
	Public Assistance	_____
	Workmen's Comp	_____
	Unemployment	_____
	Disability	_____
	Insurance	_____
	Savings	_____

Expenses

Rent/Mortgage	_____
Utilities	_____
Food	_____
Insurance- Health	_____
Insurance- Home	_____
Insurance- Car	_____
Medical	_____
Auto Payment	_____
Credit Card Debt (monthly and total)	_____
	_____
Other Expenses	_____
	_____
	_____

Assets	**Value**

(If more space needed, please attach separate sheet)

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: _____
Patient Name

_____
Street Address

_____
City, State and Zip Code

_____
Telephone number

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with documenting my medical care and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All pertinent documentation and medical records including: history and physical, discharge summary, operative reports, consultation reports, lab results, progress notes, pathology reports, pharmacy/prescription records and any other pertinent documentation.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, psychiatric care or other sensitive information. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of review, determination and consultation of program eligibility with Breast Cancer Foundation of the Ozarks and should be sent to:

Breast Cancer Foundation of the Ozarks
620 W. Republic Rd., Ste. 107
Springfield, Missouri 65807

Phone Number: 417-862-3838
Fax Number: 417-862-3830

Further, I understand:
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. I understand that this authorization is voluntary but is also a condition of eligibility for Breast Cancer Foundation of the Ozarks program and that without a signed authorization for the release of patient information, I will not be eligible for assistance.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

_____ _____
Patient Signature Date

_____
Printed Name of Patient