BREAST CANCER FOUNDATION OF THE OZARKS

APPLICATION FOR LYMPHEDEMA PROGRAM

If approved, all payments for garments will be made directly to the medical provider or medical supply company.

Name:_____ D.O.B:_____ SS#:_____
Address:_____ City:_____ Zip:_____ - _____
Telephone No.:_____ Email:_____ County:_____
Spouse:_____ Children: Other Dependents:
Medical Diagnosis:_____ _____ _____
_____ _____ _____
Physician:_____ _____ _____

What type of garment do you need? _____
_____
Other Agencies you are currently working with:_____
_____

Health Coverage: ____No ____Yes If yes, Circle TYPE: Personal Policy, Through Employer, Medicare, Medicaid
Does your coverage include lymphedema garments? _____

Amount Requested For Garment if known: _____

FINANCIAL INFORMATION:

		Monthly Income	Monthly Expenses
Employment:	Patient:	$_____	Rent/Mortgage: $_____
	Spouse:	$_____	Utilities: $_____
	Other:	$_____	Food: $_____
Retirement:	Social Security:	$_____	Insurance Health: $_____
	VA Pension:	$_____	Insurance Home: $_____
	Employee Pension:	$_____	Insurance Car: $_____
Other Income:	Alimony:	$_____	Medical: $_____
	Child Support:	$_____	Car Payment: $_____
	Investments:	$_____	Credit Card Debt:$_____
	Public Assistance:	$_____	Other Expenses:
	Workmen's Comp:	$_____	_____
	Unemployment:	$_____	_____
	Disability:	$_____	_____
	Insurance:	$_____	_____
	Savings:	$_____	_____

Assets: (If more space needed, please attach separate sheet) Value

_____ _____
_____ _____
_____ _____
_____ _____

Enclosed is a release form with information for you to send to or give your health care provider so our organization can make contact for verification of your breast cancer status if needed. This release is in accordance with HIPPA guidelines.

I hereby certify that I have developed lymphedema as a result of surgery or treatment related to breast cancer. 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., Suite 107, Springfield, Missouri 65807
OR CALL: 417-862-3838 for answers to questions in reference to this form.

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., Suite 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