BEDFORD CANCER FOUNDATION, INC.
Shelbyville, TN

APPLICATION FOR ASSISTANCE

Date: ______________ **Social Security #** _______/_____/_______

Applicant's Name: ____ **Sex:** Male Female

(first, middle and last) **Date of Birth:** _____/_____/_____

Medical Insurance: Yes No **Terms (% of Co-Pay/Deductibles):** __________________________

Insurance Provider: _______________________________________

Proof of Bedford County Residency: ____

____

Reason for Assistance: ____

(include diagnosis) ____

____

____

____

Help Needed: ____

____

____

Other Agencies Applied To: ____

(include name of agency, contact, ____

and phone number) ____

____

Applicant's Contact Information: Home Phone ___________________ Work Phone ___________________

Cell Phone ____________________ Fax Number ___________________

Email Address ____

Physical Address: ____

Previous Address (if less than 1 year): ____

Physician Contact Information: Name ____ Phone ___________________

Fax ___________________

Physician Contact Information: Name ____ Phone ___________________

Fax ___________________

Physician Contact Information: Name ____ Phone ___________________

Fax ___________________

Applicant's Emergency Contact: Name _________________________________ Relationship ___________________

(emergency contact info will be used if we Home Phone ___________________ Work Phone ___________________

are unable to contact applicant) Cell Phone ____________________ Fax Number ___________________

Email Address ____

Mailing Address ____

____

INCOME/EXPENSE INFORMATION

Monthly Income For Household: $___________________

Occupation/Source Of Income: ____

Other Income: $ ___________________ Source: ______________________________

Savings/Disposable Assets: $___________________

Life Insurance: Yes No Value: $_________________

Life Insurance Company: ______________________ Policy # ______________________

IRA or other Retirement Funds: Yes No Value: $_________________

Other Investments: ______________________________ Value: $_________________

Monthly Expenses:

Payment Type	Amount	Payment Type	Amount
______________	$__________	______________	$__________
______________	$__________	______________	$__________
______________	$__________	______________	$__________
______________	$__________	______________	$__________

*****ATTACH CURRENT TAX RETURN(S)**

*****ATTACH COPY OF RENT/MORTGAGE BILLS (if asking for help with rent or mortgage)**

CONSENT FOR ENROLLMENT

I understand and agree information supplied by me may be shared with other funding sources and community services, for benefits and planning on my behalf. I attest that I am a resident of Bedford County, Tennessee, and that I must pursue all relevant Federal, State, local, public and private resources for medical and financial assistance, in a timely fashion before, or coincidental with, receiving any financial assistance from the Bedford Cancer Foundation, Inc. I understand that I may become ineligible for services if, at any time, I have been found to have deliberately misled any representative of the Foundation. I further understand that any help I may receive from the Foundation shall be at their discretion, and in consideration for the Foundation accepting my application and considering it, I agree to indemnify the Foundation and hold it harmless from any liability associated with their review and decision regarding my application.

Applicant Signature ______________________________ **Date** ________________

Applicant Printed Name ______________________________

Witness Signature ______________________________ **Date** ________________

Witness Printed Name ______________________________

FOR INTERNAL USE ONLY:

Date Application Received _____/_____/_____

Date Application Approved / Denied (circle one) _____/_____/_____

Diagnosis ____

Date Treatment Begins _____/_____/_____ **Follow Up Date** _____/_____/_____

Estimate Date Treatment Ends _____/_____/_____ **Follow Up Date** _____/_____/_____

Date Assistance Ends _____/_____/_____ **Follow Up Date** _____/_____/_____

Amount of Assistance To Be Provided $ __________

BEDFORD CANCER FOUNDATION, INC.
Shelbyville, TN

AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI) (Medical Records)

Complete this form and take to your doctor(s) office.

Patient's Name ____

Address ____

____

Doctor's Name ____

Address ____

____

You are hereby authorized and directed to provide to Bedford Cancer Foundation, Inc. any and all information pertaining to my diagnosis of cancer and treatment of that disease. This information must be provided upon application for financial assistance and every six months as long as I am their client. This authorization is for PHI from the beginning of my treatment or testing to present. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
3. The requester is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I get a copy of this form after I sign it.
6. This authorization will expire two (2) years from its issuance.
7. I understand that if I refuse to sign, or, at any time revoke this authorization, I will become ineligible for financial assistance from the Bedford Cancer Foundation, Inc.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature ____Date __________________
(or legal representative)

Witness Signature ____Date __________________