BEDFORD CANCER FOUNDATION

APPLICATION FOR ASSISTANCE

The Bedford Cancer Foundation Application for assistance is intended to be a simple process. To be eligible for assistance from the Bedford Cancer Foundation

- You must currently be receiving treatment for your diagnosis (surgery, chemotherapy, radiation, anti-cancer medications)
- You must be a resident of Bedford County for your application to be considered.

The Foundation requires the following information to be on file and up to date:

1. Copies of your doctor's diagnosis, prognosis, and treatment plan

2. Proof of household income and source of income.

3. Itemized listing of monthly expenses. Examples include house payment or rent, electric, water, phone, cable, car payment, insurance (health, auto, etc.). **The Foundation does NOT pay medical bills, so these are not to be included in the application.**

Applications are presented for review at our monthly Board meeting, which is typically held on the **second Tuesday of each month.** New applicants must have applications complete and submitted for review no less than **5 (five) days prior** to the meeting date. Once the application is approved, you may contact the Foundation at **317.201.8530** if you require assistance or further funding. A maximum of **$5,000 per person per calendar year** is allotted.

Cathy Mercer, Board member and Application Grant Chairperson, is happy to assist by answering questions, helping with the application process, making copies, etc. Please feel free to call her at 317.201.8530.

Your completed application should be submitted to Cathy Mercer, Application Grant Chairperson. You can reach her at 317.201.8530.

BEDFORD CANCER FOUNDATION

APPLICATION FOR ASSISTANCE

Date: _____

APPLICANT INFORMATION

Applicant's Name (first, middle, Last) _____ DOB _____

Social Security Number _____ / _____ / _____ Sex: ☐ Male ☐ Female

Applicants Contact Information

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Email Address _____

Physical Address _____

_____

Previous Address (If less than 1 year) _____

_____

Proof of Bedford County Residency (Copy of Driver's license, current bill with address, etc.)

_____

Applicants Emergency Contact Information

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Email _____

Mailing Address _____

INSURANCE INFORMATION

Medial Insurance ☐ Yes ☐ No Insurance Provider _____

Terms (% of co-pay/deductibles) _____

APPLICATION DETAILS

Diagnosis: _____

Reason for Assistance:

_____

_____

Help Needed:

_____

_____

Other Agencies Applied To (Include name of agency, contact, and phone number):

_____

_____

BEDFORD CANCER FOUNDATION

APPLICATION FOR ASSISTANCE

PHYSICIAN CONTACT INFORMATION

Name _____ Phone _____
Fax _____
Name _____ Phone _____
Fax _____
Name _____ Phone _____
Fax _____

INCOME INFORMATION

Monthly Income for Household $ _____
Occupation / Source of Income _____
Other Income _____

Monthly Expenses:

_____ Payment Type	$_____ Amount	_____ Payment Type	$_____ Amount
_____ Payment Type	$_____ Amount	_____ Payment Type	$_____ Amount
_____ Payment Type	$_____ Amount	_____ Payment Type	$_____ Amount
_____ Payment Type	$_____ Amount	_____ Payment Type	$_____ Amount

*****Attach Copy of any bills you are requesting assistance with – mortgage, rent, water, power, etc*****

CONSENT FOR ENROLLMENT

I understand and agree information supplied by me may be shared with the Bedford Cancer Foundation Board of directors. I attest that I am a resident of Bedford County, Tennessee, and I have been a resident of Bedford County for at least 6 months. I understand that the Bedford Cancer Foundation reserves the rights to request a copy of my tax returns at any time. I understand that any help I may receive from the Foundation shall be at their discretion.

Applicant Signature _____ Date _____

Applicants Printed Name _____

Witness Signature _____ Date _____

Witness Printed Name _____

BEDFORD CANCER FOUNDATION

APPLICATION FOR ASSISTANCE

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 effect 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 _____