Application No. _____

Received On: _____

The information requested below is needed to complete the patient's application for financial assistance with co-pays and deductibles associated with treatment of a current cancer diagnosis. Both the provider and the patient will be notified of the application determination. If you have any questions about this application or the application process, please contact the Cancer Care Network Foundation at admin@cancercarenetworkfoundation.org. [At this time, we do not provide cash assistance for non-treatment related needs. We are also unable to provide aid to patients outside of California.]

Applicant Information:

_____

First Name | Last Name

_____

Date of Birth | Social Security Number

_____

Address | City | State | Zip

_____

Contact Person (if other than Applicant) | Telephone | Email

Section 1 (To be completed by Healthcare Provider)

Physician: (Regardless of specialty, who is responsible for ongoing patient care)

_____

Provider Name | Title

_____

Specialty | Email/Website

_____

State License No. | Physician NPI Number

_____

Treating Facility Name

_____

Address | City | State | Zip

_____

Contact Person | Telephone | Email

_____

Tax ID Number

Please return this completed form to admin@cancercarenetworkfoundation.org or mail to:
Cancer Care Network Foundation
1531 N. Columbus Ave.
Glendale, CA 91202

Application No. _____

Received On: _____

Section 2

DIAGNOSIS AND THERAPY

**Please attach a copy of your Doctor's Summary Note to this application.*

Diagnosis:

_____

_____

State of Disease:

_____

_____

Current Therapy:

_____

_____

_____

Length of Treatment:

_____

_____

_____

Health Care Providers Statement of Financial Assistance Necessity of Patient

I verify that the information in this portion of the application is complete and accurate. As the treating physician for the patient, I verify that I have prescribed the treatment regimen indicated above, based on my professional judgment of medical necessity. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. I also understand that, if eligible, assistance may be limited by the terms and conditions as established by the Foundation and that the Foundation reserves the right at any time and for any reason, without notice to modify this application and modify or discontinue any assistance provided.

_____ _____

Healthcare Provider Signature **Date**

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Cancer Care Network Foundation
1531 N. Columbus Ave.
Glendale, CA 91202

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Section 3

PATIENT FINANCIAL INFORMATION:

Marital Status? _____Single _____Married _____Domestic Partner _____Divorced

What is your current employment status?
_____Employed _____Unemployed _____Retired _____Disabled

If unemployed or disabled, what date did you begin receiving benefits? _____

Are you or other members of your household required to file a federal tax return? __Yes __ No

Are you claimed as a dependent on any federal tax return? __Yes __ No

How many people live in your household and are claimed as dependents on your tax return? (Example: You, your spouse, and two children = 4) _____

What was your family's gross annual income last calendar year? _____

Required Documentation: (Please submit the following information with your application).

1. Diagnosis (MD Summary Note) and MD Signature.
2. Valid California ID (i.e. driver's license, etc.).
3. Explanation of Benefits (EOB) Form from your Insurance Company
4. Bill/Invoice for co-pay or deductible due to your provider.
5. Income verification for all sources of household income. This may include:
    - Two most recent payroll stubs and/or social security and pension statements.
    - Copy of your most recent 2 years federal tax returns. If you are required to file, or if you are claimed as a dependent, a copy must be included with your application.
    - Bank statements (2 months).
    - Copies of both the front and back of your medical and prescription drug insurance card(s).
    - Current credit report (free credit reports are available online).

If you are not: required to file a federal tax return, or if your household income has changed significantly since you last filed a federal tax return, please call the Cancer Care Network Foundation (818-800-5806) to determine what information you should submit to verify household income.

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Section 4

FUNDS REQUEST

Please list your co-pays or deductible amounts below:

Date	Bill/Invoice Description	Amount	Check one:
			☐ Co-Pay ☐ Deductible
			☐ Co-Pay ☐ Deductible
			☐ Co-Pay ☐ Deductible
			☐ Co-Pay ☐ Deductible
			☐ Co-Pay ☐ Deductible
	TOTAL AMOUNT REQUESTED		

IMPORTANT INSTRUCTIONS:

1. Enter the date, name (payable to) and amount of each bill and indicate whether the bill is for a co-pay or deductible. (Use additional Funds Request Forms if needed.)

2. Attach a copy of the bill or invoice to this form. Name, date and amount of invoice must match with entries on this form.

3. If you are requesting a reimbursement of co-pays or deductibles, please include your canceled check, credit card statement or other proof of payment along with the original invoice.

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Section 5

PERSONAL STATEMENT

Please provide a brief description of your need and a little about yourself.

_____

_____

_____

_____

_____

_____

APPLICANT DECLARATION

I verify that the information provided in my application is complete, accurate and true. I further understand that reported financial information may be verified by an audit as deemed necessary by the Foundation. I understand that if I am approved for assistance by the Cancer Care Network Foundation, assistance will terminate if the Foundation becomes aware of any fraudulent activity related to my application or the assistance provided to me by the Foundation. I understand that any assistance the Foundation may provide is limited to the terms and conditions established by the Foundation and that the Foundation reserves the right at any time and for any reason, without notice, discontinue assistance.

I authorize the Foundation and its employees, third party administrators, agents and other representatives to obtain health Information from my health care providers, insurance coverage information from my employer or insurance company (ies) *and* other information necessary to complete the application process *or* verify the accuracy of any information provided with this application.

I authorize the Foundation and its employees, agents, third party contractors and service providers engaged with the Foundation's assistance programs to use my social security number and/or additional demographic information (including, but not limited to, addresses, phone numbers, individual tax identification numbers, names of family members, etc.) to access and use my credit information and other information derived from public and other sources to evaluate my income and financial resources for the purposes of determining my financial eligibility for assistance through the Foundation.

_____ _____

Patient Signature **Date**

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1531 N. Columbus Ave.
Glendale, CA 91202

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Section 6

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____

Patient Name

_____

Date of Birth Social Security Number

In order for me for receive assistance through the Cancer Care Network Foundation, I authorize my health care provider(s) and my insurance company(ies) to disclose to the Foundation and its employees, third party administrators, agents and other representatives (collectively "the Foundation"), information about me, my current medical condition and my health insurance coverage. This information can include spoken or written facts about me as well as copies of records from my health care provider(s) and my insurance company (ies) about my health or health care.

I understand that my health care provider (s} and insurance company (ies) will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however if I do not sign this
Authorization, I will not be eligible to receive assistance through the Foundation. I may revoke this authorization at any time by mailing or faxing a signed letter of revocation to the Foundation at the address listed below, but if I revoke this authorization, I will no longer be able to receive assistance through the Foundation. Additionally, I can tell my health care provider(s) and my insurance company (ies) in writing that I do not want them to share any more information with the Foundation, but it will not change any actions the Foundation, my health care provider(s) or my insurance company (ies) took before I revoke this authorization.

I understand that the Foundation will use and give out this information to see if I qualify for assistance and to run the Foundation. In addition, the Foundation may use and give out my information to refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my drugs. I understand that the Foundation will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This authorization expires the later of one year after the date it is signed or until I am no longer participating in the Foundation's program. I am entitled to a copy of this authorization.

I verify that the applicant has authorized me to sign, on his or her behalf, the "Declaration" and the "Authorization to Release Medical Information" above/below, which I have read to the Applicant In full. By signing this, I am attesting to the fact that I have received such intentional and informed authorization from the applicant to sign the "Declaration" and the "Authorization to Release Medical Information" on his/her behalf.

_____ _____

Patient Signature **Date**

Please return this completed form to admin@cancercarenetworkfoundation.org or mail to:
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Glendale, CA 91202

Application No. _____

Received On: _____

WAIVER AND RELEASE OF LIABILITY

In consideration for being potentially considered to participate in programs, events, and or activities sponsored by the Cancer Care Network Foundation, I, for myself, my executor, administrators, heirs, and anyone entitled to act on my behalf, hereby waive discharges and covenant not to sue Cancer Care Network Foundation, its management, officers, board members, employees, members, sponsors, licensees, volunteers, their successors, and all cooperating businesses and organizations, the event site, organizers, or their representatives, for any and all liability, claims, demands, damages, causes of action, losses, or expenses arising out of my participation in the event and any related activities.

I understand that I may be photographed, filmed, or videotaped in connection with my involvement with Cancer Care Network Foundation. I hereby irrevocably grant to Cancer Care Network Foundation, its affiliates, licensees, and collaborators the absolute right and permission to distribute, publish, exhibit, digitize, broadcast, display, reproduce, photograph, videotape or otherwise use my name, picture, portrait, likeness, writings or biographical information (including, if applicable, information regarding my disease diagnosis, prognosis and treatment), and audiotape and/or videotape recordings and sound or silent motion pictures of me in any manner or media whatsoever anywhere in the world in perpetuity for any lawful purpose whatsoever, including without limitation, for editorial, educational, promotional, and advertising purposes, for the solicitation of contributions, as evidence in litigation, and for any other purposes in furtherance of the purposes and objectives of Cancer Care Network Foundation. I hereby release discharge and agree to hold harmless Cancer Care Network Foundation and its employees or agents, affiliates, legal representatives or assigns, and all persons acting under its permission or upon its authority, from any liability by virtue of any publication of my likeness, including, without limitation, claims for libel or invasion of privacy. I further agree that Cancer Care Network Foundation shall be the exclusive owner of all copyright and other rights in such media.

I have carefully read this Waiver and Release of Liability and fully understand its contents. I am at least 18 years of age and I am competent to contract in my own name. I am aware that this is a release of liability and a binding contract between myself and the persons and entities mentioned above and I sign it of my own free will. I understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing this Waiver and Release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_____

First Name Last Name

_____

Primary Contact Number Email Address

_____ _____

Signature **Date**

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