CIRCLE OF HOPE

APPLICATION FOR MEDICAL FINANCIAL ASSISTANCE

Please Print Clearly Date Application Received: _____

Name: _____
First Middle Last

Residence Address: _____Apt.#_____

City: _____ State: CA Zip Code: _____

PHONE: Home: _____Work: _____Cell: _____

E-mail Address: _____

Date of Birth: _____/_____/_____Gender (Circle One) M____ F____ Other____ Prefer Not To Say_____

Emergency Contact: _____ Phone: _____

Relationship_____

MEDICAL STATUS:

Diagnosis: _____

_____

Currently in Treatment: Yes____ No ____ Type of Treatment: _____

Chemo/Radiation Completed: Yes____ No____ If Yes, what type of adjuvant treatment are you receiving?

(Hormonal: example- Tamoxifen or similar)_____

Projected Treatment Plan: _____

_____

_____

REFERRING INFORMATION:

How did you hear out about Circle of Hope? _____

If you were referred by a medical professional or agency, please provide the following:

Doctors Name:_____

Medical Facility: _____

Contact Name: _____ Position/Title: _____

Contact's Phone: _____ Contact's Fax: _____

E-Mail Address: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____

Address: _____

Insurance Type: PPO___ HMO___ POS___ Other_____

Co-Payments for Primary Insurance: Physician Visits $_____Prescriptions $_____ Hospital $_____

Diagnostic Testing $_____ Chemotherapy $_____Radiation $_____Other $ _____

Secondary Insurance Carrier: _____

Address:_____

Insurance Type: PPO___ HMO___ POS___ Other_____

Co-Payments for Secondary Insurance: Physician Visits $_____ Prescriptions $_____ Hospital $_____

Diagnostic Testing $_____Chemotherapy $_____Radiation $_____Other $ _____

Annual Maximum Deductible (Out of Pocket Expenses) per:

Individual $_____ Family $_____

Health Savings Account (HSA) funds available $_____

HOUSEHOLD INFORMATION:

Members of Household:

First name_____ Age_____ Relationship_____ Other_____

First name_____ Age_____ Relationship_____ Other_____

First name_____ Age_____ Relationship_____ Other_____

First name_____ Age_____ Relationship_____ Other_____

First name_____ Age_____ Relationship_____ Other_____

Are you employed? Yes___ No___ Occupation: _____

Name of employer: (or business if self-employed) _____

Address of employer:_____

Average monthly gross household income $_____ (attach proof of income*)

Spouse/partner occupation: _____

Name of Spouse/Partner employer: (or business if self-employed) _____

Address of employer:_____

Average monthly gross household income$_____ (attach proof of income*)
Estimated amount of liquid assets (cash and other assets available to be converted into cash:

_____

*Proof of income required, but not limited to the last three months of pay stubs, 3 months bank statements for all savings and checking accounts, public assistance, or previous and current year's full tax returns.

Is your household receiving, or do you anticipate receiving any other income in the form of, but not limited to, public assistance, disability payments, Social Security income, unemployment benefits, retirement income, alimony or child support, Veteran's benefits, rental income or any other form of income? Yes_____ No_____

If yes, please indicate source(s) and average monthly amount:_____

_____

AVERAGE MONTHLY FAMILY EXPENSES: **Monthly Average**

1. Rent or mortgage (including taxes & insurance) $_____
2. Utilities $_____
3. Health/life insurance premiums $_____
4. Car loan(s)/ payment $_____
5. Gasoline $_____
6. Medical expenses **not** covered by insurance $_____
7. Childcare $_____
8. Food $_____
9. Credit Card debt: $_____
10. Other: _____ $_____

Additional information you would like us to consider: _____

_____

_____

_____

*__***Confidentiality Statement***__: The use of this application and separate signed medical release form are used solely for the purpose of determining eligibility for assistance from the Circle of Hope, Inc. This information is kept in confidence and used within the Circle of Hope Inc., however, at times information may be shared between the Circle of Hope, Inc. and other healthcare providers as necessary to determine eligibility or on-going eligibility consideration for financial assistance. Any person who makes or causes to be made knowingly false or fraudulent material statements or material misrepresentation for the purpose of obtaining or denying assistance from Circle of Hope, Inc., is guilty of a felony and may be prosecuted.

__*Statement of Need***__: I affirm that I am in need of assistance from Circle of Hope, Inc. and will use any financial assistance provided to me toward bona-fide expenses related to my diagnosis of cancer. I am a citizen or legal resident of the United States and I currently live, work or receive all medical treatments for cancer in the Santa Clarita Valley.

Please identify a person(s) authorized to discuss your application, medical (HIPAA) and financial, including legal representation information with Circle of Hope, Inc. should you be unavailable or unable to provide information:

Name: _____ Relationship: _____

Address: _____

Phone: _____ E-Mail Address: _____

I have read, understand and agree to the above *Confidentiality Statement**, *Statement of Need*** and all above statements. I have answered all questions on this application truthfully and to the best of my ability. I also agree to provide Circle of Hope, Inc. any changes or updates to information stated on this application s they occur.

Signature: _____Date: _____

Note: Please include all required forms and documentation as outlined in the Client Bill of Rights

Please return all applications, forms, and documentation to address below or email to: info@circleofhopeinc.org

Support for this program is based on the availability of funds and application approval. Circle of Hope reserves the right to adjust or change approval criteria without notification.

CIRCLE OF HOPE