Patient Assistance Application

Name (First, Middle, Last) : _____

Preferred Name: _____ Female: ___ Male:___

Address: _____

City: _____ County: _____State: _____ Zip: _____

Date of Birth:_____ Age: _____ Last 4 digits of SS #: _____

Home #: _____ Cell #:_____ Work #: _____

Email Address: _____

Ethnic Background: White__African Amer.__ Hispanic __American Indian__ Asian__Multi-Ethnic__Other__

Church Affiliation/Denomination: _____

Home Congregation: _____

Married: Yes ___ No ___ Spouse/Partner Name:_____

Age:_____ Cell Phone: _____ Work Phone: _____

Email Address:_____

Additional Contact: _____ Relationship:_____

Home #: _____ Cell #:_____ Work #:_____

Email Address: _____

Number of residents living in household: _____

Please list names, ages, and ethnic backgrounds of all members living in home:

_____

Patient Employment Status: _____ Income: _____

Spouse/Partner Employment Status: _____ Income: _____

Other Income Sources: _____

Total Monthly Household Income: _____

Are you currently receiving Food Stamps? Yes ___ No ___ Monthly Amount: _____

Do you currently have health insurance? Yes ___ No ___

Insurance Provider: _____ Co-Pay: _____

Deductible: _____ Prescription Coverage: Yes ___ No ___

Pharmacy: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Please list current medications and cost:

_____

Cancer diagnosis (type of cancer): _____

Stage of cancer: _____ Date of diagnosis: _____

Please share how you were diagnosed:

_____

Primary Care Physician: _____

Phone: _____ City: _____

Radiation Oncologist: _____ Phone: _____

Oncology Group: _____ City: _____

Medical Oncologist: _____ Phone: _____

Oncology Group: _____ City:_____

Please include a letter of diagnosis and treatment plan from oncologist

Have you discussed your financial needs with your doctor's staff or treatment center? Y___ N___

Please list all your monthly expenses below. If additional space is needed, please attach separate sheet to application:

_____

Please list your greatest need:

_____

How were you referred to Pink Out For Hope?

_____

I give Pink Out For Hope permission to obtain and share my protected healthcare information in coordination with possible benefits from Pink Out For Hope. I understand that by signing this form it does not guarantee financial assistance and it also releases Pink Out For Hope from any form of liability.

Signature: _____ Date: _____

Relationship to Patient: _____

Pink Out For Hope does not discriminate based on any information received.

P.O. Box 263, Pleasant View, TN 37146 info@pinkoutforhope.org www.pinkoutforhope.org

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