



## **Directions for Completing Cancer Financial Assistance Packet**

Our mission is to provide financial assistance to cancer patients residing in Iowa County, Wisconsin. In order to ensure as much confidentiality as possible during the application process, your application will be referenced by a case number and not your name. We are dedicated to fairness and it is our goal to provide some financial assistance to all approved applicants.

### **1) Cancer Financial Assistance Application**

Please provide as much information as possible so we may make an informed decision. You must sign and date the application.

### **2) Authorization for Disclosure of Health Information**

You must complete two authorization forms. You must sign and date both forms. Provide one form to your doctor and send the second form to Iowa County Cancer Coalition, Inc.

### **3) Diagnosis Verification**

This form must be completed and signed by your doctor. Once completed, provide the form to Iowa County Cancer Coalition, Inc.

**The three forms must be returned to the following address:**

**Iowa County Cancer Coalition, Inc.  
P.O Box 36  
Cobb, WI 53526**

**Once your application is verified, it will be considered at the next board meeting. The volunteer board meets the first Monday of each month.**



Iowa County Cancer Coalition, Inc.  
PO Box 36  
Cobb, WI 53526

**Application for Cancer Financial Assistance**

Applicant Name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ (city) (state) (zip code) (county)

Please provide the name and phone number of an additional contact person to act on your behalf:

Additional Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Cancer Diagnosis: \_\_\_\_\_

Physician's Name and Office/Clinic: \_\_\_\_\_

**Request for Assistance:** Please explain in detail the assistance you are requesting from Iowa County Cancer Coalition, Inc. Examples include gas cards, grocery cards, utility payment, house or rent payment, medical and pharmacy bills:

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I currently reside in Iowa County, Wisconsin, I am currently diagnosed with cancer and I am or will be receiving treatment related to cancer. I request financial assistance from Iowa County Cancer Coalition, Inc.

How did you hear about the Iowa County Cancer Coalition?

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Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**PATIENT INFORMATION:**

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Date of Birth/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**AUTHORIZE DISCLOSURE TO:**

**AUTHORIZE DISCLOSURE BY:**

Iowa County Cancer Coalition, Inc.

Name of Health Care Provider:

PO BOX 36

\_\_\_\_\_

COBB, WI 53526

Address: \_\_\_\_\_

\_\_\_\_\_

Fax Number: \_\_\_\_\_

Attention: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** Verification of current cancer diagnosis and treatment related to cancer.

**PURPOSE FOR DISCLOSURE:** To validate current cancer diagnosis and treatment related to cancer for purposes of considering a financial assistance application to Iowa County Cancer Coalition, Inc. A Diagnosis Verification Form must be completed by the doctor.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed form copy. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

**EXPIRATION DATE:** This authorization is good until the following date(s) \_\_\_\_\_ or 90 days from signed date.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE OF PATIENT/LEGAL REP:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_

**(If signed by other than patient, state relationship and authority to do so)**

**\*\* PROVIDE THIS COPY TO IOWA COUNTY CANCER COALITION, INC.**

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**PATIENT INFORMATION:**

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Date of Birth/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**AUTHORIZE DISCLOSURE TO:**

**AUTHORIZE DISCLOSURE BY:**

Iowa County Cancer Coalition, Inc.

Name of Health Care Provider:

PO BOX 36

\_\_\_\_\_

COBB, WI 53526

Address: \_\_\_\_\_

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\_\_\_\_\_ Date: \_\_\_\_\_

(If signed by other than patient, state relationship and authority to do so)

**\*\* PROVIDE THIS COPY TO YOUR DOCTOR**



**Iowa County Cancer Coalition, Inc.**  
**PO Box 36**  
**Cobb, WI 53526**

## **DIAGNOSIS VERIFICATION FORM**

I verify that \_\_\_\_\_

(Patient's name)

has a current diagnosis of cancer and is/will be receiving treatment related to cancer.

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_