IOWA COUNTY CANCER COALITION
CARE. COMFORT. COPE.

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.

4) **Eligibility**

Applicants are eligible to apply once every 12 months

The three forms must be returned to the following address:

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

IOWA COUNTY CANCER COALITION
CARE. COMFORT. COPE.

For Office Use Only
APP#_____
Approval Date:_____
Dispersement Date_____

Please check: ☐ 1st time applying for assistance
☐ 2nd time applying for assistance
☐ 3rd time applying for assistance

Application Form

Applicant Name (please print): _____ Phone: _____

Address:_____

_____

(city) (state) (zip) (county)

Date of Birth: _____

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. Examples include gas cards, grocery cards, utility payment, house or rent payment, medical and pharmacy bills.

_____

_____

_____

_____

I currently reside in Iowa County, Wisconsin, I am currently diagnosed with cancer. I am or will be receiving treatment related to cancer, I request financial assistance from Iowa County Cancer Coalition. (EX: treatments may include chemotherapy, radiation, doctor visits, pain management, terminal, hospice)

Applicant's Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT IOWA COUNTY CANCER COALITION? (choose all that apply):

- ☐ **Social Media**
- ☐ **Newsletter**
- ☐ **ICCC Board Member**
- ☐ **Attended an Event**
- ☐ **Health Care Professional**
- ☐ **Another Applicant/Friend/Family**

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:

Iowa County Cancer Coalition, Inc.

PO BOX 36

COBB, WI 53526

AUTHORIZE DISCLOSURE BY:

Name of Health Care Provider:

_____

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:

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PO BOX 36

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**** 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: (_____) _____

Please return form to above address.