LINDA YOUNG OVARIAN CANCER SUPPORT PROGRAM

HealthAlliance Oncology Support Program 80 Mary's Avenue, Kingston, NY 12401
Tel: (845) 339-2071 – Fax: (845) 339-2082

Benedictine Health Foundation, Inc.: 105 Mary's Avenue, Kingston, NY 12401
(Fund Administrator Tax ID: 22-2243537) Tel: (845) 334-3017 – Fax: (845) 334-4574

Patient Financial Assistance Application Form

SECTION 1: TO BE COMPLETED BY PATIENT – PLEASE PRINT

_____

Patient Name: First Middle Initial Last

_____

Mailing Address: (PO BOX or Street Address/Apartment #)

_____

City State Zip Code

PATIENT'S SS NUMBER (last 4 digits): _____ DOB: Month ____ Year _____

PATIENT'S TEL. #: (____) _____ -_____ E-MAIL: _____

PREVIOUS YEAR ANNUAL GROSS HOUSEHOLD INCOME: $_____

CURRENT YEAR PROJECTED GROSS HOUSEHOLD INCOME: $_____

Please attach copy of income verification **____ Family Income ____ Single Income**

□ ***Most recent W-2 (s)*** □ ***Most recently filed federal income tax return for household***
□ ***Medicaid Card*** □ ***Other type of income verification from state or federal agency)***

By signing below, I attest that the information provided is complete and accurate. I understand that I may be required to provide additional information and documentation at the request of the Benedictine Health Foundation, Inc. (Fund Administrator) for the purpose of determining my eligibility to participate in the patient assistance program. I agree to inform the Benedictine Health Foundation, Inc. of any change or circumstance that may impact my eligibility in this program. Any untruthful or fraudulent information provided, or my refusal to cooperate with the requirements of this Fund may be grounds for denial of assistance. I understand that the Fund may engage a third party to assist with the services of this program and I consent the Fund to release to the necessary third party any information I supply in connection with this application that is necessary for such administration. Except to the consent required by law or for the purpose of administering this program, I understand that the information provided will be kept confidential.

_____ _____

PATIENT or LEGAL REPRESENTATIVE SIGNATURE **DATE**

PLEASE INDICATE BELOW ASSISTANCE NEEDED (Total Maximum Annual Amount is $500):

( ) GIFT CARDS FROM HANNAFORD SUPERMARKETS: Amount requested ($50 increments): $_____

( ) GIFT CARDS FROM STEWART'S: Amount requested ($50 increments): $_____

( ) MEDICAL NECESSITIES not covered by health insurance: (please specify) _____

( ) OTHER ASSISTANCE: (please specify) _____

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SECTION II: TO BE COMPLETED BY HEALTHCARE PROVIDER

PLEASE PRINT:

PATIENT'S NAME: _____

PHYSICIAN'S NAME: _____PRACTICE NAME: _____

TEL: ( )_____ FAX: ( ) _____

PATIENT DIAGNOSIS: _____TREATMENT: _____

PHYSICIAN OR REPRESENTATIVE'S SIGNATURE: _____

Please Return Completed/Signed Application with all appropriate documentation to:

HealthAlliance Oncology Support Program
Mail: 105 Mary's Avenue, Kingston, NY 12401
Physical Address: 80 Mary's Avenue, Kingston, NY 12401
Tel.: (845) 339-2071 / **Fax:** (845) 339-2082

or

Benedictine Health Foundation, Inc.
PO Box 2250
Kingston, NY 12402
Tel: (845) 334-3017 / **Fax:** (845) 334-4754

SECTION III: (For Internal Use Only):

Application reviewed and submitted by HealthAlliance Oncology Support Staff:

Name/Title: _____ **Signature: _____**
Print

Date Submitted to BHF: _____ Date Received by BHF: _____

Application Approved: _____ Denied _____ (please note explanation in comments section)

Amount Approved: $_____

Approved by: _____ _____
Barbara Klassen, Executive Director **Date**

Comments:

_____
_____
_____
_____
_____
_____