Sandusky County
Cancer Care Fund

Application for Assistance

United Way of Sandusky County, Inc.
826 West State Street, Fremont, Ohio 43420
Phone: 419-334-8938 ~ Fax: 419-334-8930

In order to qualify, please complete the following:

- ☐ The attached application (page 1)
- ☐ The Physician Authorization for Services Form verifying you have a cancer diagnosis and are currently receiving treatment (page 2)
- ☐ Supply proof of Sandusky County residency; use any one of the following forms:
  - a current driver's license
  - state ID
  - most recent utility bill in your name
- ☐ Schedule a 10 to 15 minute appointment to discuss the program:
  - call the United Way of Sandusky County office at: 419-334-8938

If you have any questions or concerns, please feel free to call the United Way of Sandusky County office. We hope that the Sandusky County Cancer Care Fund can be of assistance to you.

United Way of Sandusky County Staff

APPLICATION FOR ASSISTANCE

United Way
Sandusky County
Cancer Care Fund

DATE: _____

PLEASE CHECK ONE:

☐ Initial Application ☐ Re-Application

CLIENT INFORMATION:

Name:_____

Address:_____

City: _____ Zip Code: _____

IS YOUR ADDRESS IN SANDUSKY COUNTY? ☐ Yes ☐ No

Telephone: _____ E-Mail Address: _____

Date of Birth: _____ Marital Status: _____

☐ Employer _____ ☐ Retired

☐ Insurance Company _____ ☐ Medicaid/Medicare

Do you have Prescription Coverage? ☐ Yes ☐ No Are you a Veteran? ☐ Yes ☐ No

How did you hear about the Sandusky County Cancer Care Fund? _____

_____

At what facility are you receiving treatment? _____

_____

ADDITIONAL CONTACT PERSON:

Name: _____

Relationship: _____ Do you have Power of Attorney? ☐ Yes ☐ No

Address: _____

City: _____ Zip Code: _____

Telephone: _____ E-Mail Address: _____

HIPPA PRIVACY AUTHORIZATION

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act)

Authorization:

I authorize the United Way of Sandusky County Cancer Care Fund to use and disclose protected health information to discuss my care and treatment related to payment of claims to verify such claims submitted are cancer related.

All information on this form is strictly confidential and will be treated as such by the United Way of Sandusky County Cancer Care Fund.

Signature: _____ **Date:** _____

PHYSICIAN AUTHORIZATION FOR SERVICES

Your patient, _____, has applied for services from the United Way of Sandusky County Cancer Care Fund; we require the following information before he/she is able to receive assistance:

Is he/she currently one of your patients? ☐ Yes ☐ No

Is he/she in current cancer *treatment? ☐ Yes ☐ No
*treatment is based upon your professional determination

Diagnosis: _____

Physician Contact Information:

_____ _____
Name Phone Number

_____ _____
Address Fax Number

_____ _____
Signature Date

PLEASE RETURN THIS COMPLETED APPLICATION TO:

United Way of Sandusky County, Inc.
826 West State Street, Fremont, Ohio 43420
Phone: 419-334-8938 ~ Fax: 419-334-8930