



Sandusky County Cancer Care Fund

c/o United Way of Sandusky County • 826 West State Street • Fremont • OH 43420

Dear Interested Applicant:

Enclosed is an application for assistance from the Sandusky County Cancer Care Fund. In order to qualify, please complete the following:

- Complete the enclosed application
- Have your physician or treatment center complete the enclosed "Physician Authorization for Services" form verifying you have a cancer diagnosis and are currently receiving treatment
- Once you have the documentation ready, please give me a call at 419-334-2720 to set up an appointment so we can go over the program and how it may best assist you
- Supply proof of Sandusky County residency by bringing a current driver's license, state ID, or most recent utility bill in your name to your appointment

If you have any questions or concerns, feel free to contact me. I hope that the Sandusky County Cancer Care Fund can be of assistance to you.

Sincerely,

Hilary Frater
Program Specialist
Phone: 419.334.8938
Fax: 419.334.8930



APPLICATION FOR ASSISTANCE



Sandusky County Cancer Care Fund
Reducing the burden of cancer since 2007



Date: _____

Please check one:

Initial Application Re-Application

Patient's 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? _____

Next of Kin and/or Contact Person:

Name: _____

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

Address: _____

City: _____ Zip Code: _____

Telephone: _____ E-Mail Address: _____

PATIENT APPLICATION – PAGE 2

Physician: _____ Phone: _____

Address: _____

City, State, Zip: _____

Diagnosis: _____

Indicate the Type of Assistance you might be seeking:

- Gas or mileage reimbursement for transportation to doctors and/or treatment.
 - Financial assistance with medications.
 - Financial assistance with co-payments or medical bills.
 - Assistance with nutritional supplements.
 - Assistance with wig or prosthesis.
 - Other: Please be specific: _____
- _____

Can you please tell us briefly why you need assistance from the Sandusky County Cancer Care Fund?

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 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 Sandusky County Cancer Care Fund.

Signature: _____ Date: _____

PLEASE BRING THIS COMPLETED FORM TO YOUR SCHEDULED APPOINTMENT.

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



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826 West State Street, Fremont, Ohio 43420
419-334-8938

PHYSICIAN AUTHORIZATION FOR SERVICES

Your patient, _____, has applied for services from the 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

Diagnosis: _____

Physician Contact Information:

Name

Phone Number

Address

Signature

Date

Please return this form to your patient; mail it to the Sandusky County Cancer Care Fund at 826 W. State St., Fremont, OH 43420; or, fax it to 419-334-8930.