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

United Way of Sandusky County

APPLICATION FOR ASSISTANCE

DATE: _____

PLEASE CHECK ONE:

☐ Initial Application ☐ Re-Application

CLIENT'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? _____

_____

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 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:** _____

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 COMPLETED APPLICATION TO:

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