Memorial HEALTH FOUNDATION

Oncology Patient Financial Assistance Program

Name: _____ Today's Date: _____

Medical Record #: _____ Date of Birth: _____ Gender: _____

Race/Ethnicity: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Address: _____ City: _____ Zip: _____

Telephone #:_____ Email: _____

Emergency Contact: _____ Emergency Contact #: _____

Are you currently receiving any of the the following benefits? Check all that apply:

☐ Medicare ☐ Medicaid ☐ SNAP ☐ Social Security Disability ☐ None

Do you have prescription drug coverage? No ☐ Yes, provider: _____

Are you receiving funding assistance currently? No ☐ Yes, from: _____

List spouse, children, and others who may be living in your home (if applicable):

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Current Cancer Diagnosis:

Type of cancer: _____ Date of diagnosis: _____

Please summarize the applicant's treatment plan: _____

_____

_____

If applicant has a legal guardian, name of parent of guardian: _____

I am a Memorial Oncology & Hematology/Memorial Health patient: ☐ Yes ☐ No

Financial assistance being requested:
Check all that could apply. Please be aware that our financial assistance is not for living expenses such as rent, mortgages, utility payments, or food. Funds are limited and based on availability.

☐ Co-pays
☐ Cancer-related prescriptions
☐ Mileage reimbursement

Thank you for completing this application. False or misleading information may result in denial of assistance. We will review this information and contact the person requesting assistance.

All information is strictly confidential. Please provide the completed form to the Memorial Health Foundation by mail to the address below or you may provide it to your patient navigator.

Memorial Health Foundation
500 London Avenue
Marysville, Ohio 43040

If you have questions, please call the Memorial Health Foundation at (937) 578-4272.

I certify that I am currently being treated for cancer at Memorial Health. I understand that the Oncology Patient Financial Assistance Program will pay per diagnosis year up to, but no more than, $200 for co-pays and $600 ($100 per month) for cancer-related prescriptions filled at Dave's Pharmacy. I also understand that for transportation, I can receive up to $400 per diagnosis year, reimbursed at $.15 per mile.

_____ Initial here if you wish to consent that the information within this application can be shared between Memorial Oncology & Hematology to the Memorial Health Foundation and Dave's Pharmacy.

Appicant/Parent/Guardian Signature: _____

Print Name: _____

If Guardian, relationship to applicant: _____

Date: _____

To be completed by your physician, physician's office, or delegated personnel.

Date of diagnosis: _____ Primary cancer: _____

State of cancer: _____

Check one: ☐ New diagnosis ☐ Recurrence

In active treatment? ☐ Yes ☐ No

If yes, please check all that apply:

- ☐ Chemotherapy (Circle one: IV or PO)
- ☐ Radiation
- ☐ Clinical Trial
- ☐ Surgery
- ☐ Hormonal

Is the patient receiving any funding assistance from Logan County Cancer Society or an outside agency?

☐ Yes ☐ No ☐ Unsure

Physician Name: _____

Signature of staff member completing this section: _____

Staff Name/Title: _____

Phone: _____

Email Address: _____