ANGEL FUND FOUNDATION

(Please use dark ink or type)

Note: This application is for assistance with medical expenses for cancer patients who meet the set criteria listed on the separate page.

DATE_____ REFERRED BY_____

NAME _____
First Name Middle Name Last Name

ADDRESS _____
Street

_____
City State Zip Code

PHONE _____ CELL PHONE_____

BIRTHDATE _____ GENDER ___M ___F US CITIZEN ___Y ___N

LEGALLY DISABLED ___Y ___N MARITAL STATUS _____

CONTACT PERSON IF OTHER THAN SELF _____PHONE #_____

CANCER DIAGNOSIS _____ DATE OF DIAGNOSIS _____

PHYSICIANS' NAME_____ OFFICE PHONE # _____

PLACE OF TREATMENTS (if applicable):_____

Please give a brief history of your cancer illness (screening, diagnosis, treatments, etc.) and why you need assistance from Angel Fund Foundation:

_____

_____

_____

_____

_____

_____

_____

_____

revised August, 2013

MEDICAL EXPENSES:

Please list all unpaid medical expenses related to your cancer that you are unable to pay and are not covered for reimbursement by any government or private sources. Include doctor visits, medications, treatments, procedures, medical supplies, etc. Please include copies of these medical bills for which you need financial assistance. (If approved, AFF pays directly to the medical provider or center.)

1.

2.

3.

4.

5.

6.

7.

8.

Angel Fund Foundation will not pay or provide more in medical payments for eligible cancer patients than the discount given to other medical providers with an insurance or Medicare discount.

INSURANCE INFORMATION:

MEDICARE/MEDICAID: Is the cancer patient eligible for Medicare or Medicaid? Y ___ N ___

Have you ever been turned down for Medicare or Medicaid assistance? Y___ N ___
If yes, please provide a copy of the denial letter.

Do you have any kind of medical insurance Y ___ N ___
If yes, what kind? (Check all the applies)
___ Medicare A
___ Medicare B
___ Medicaid
___ Veterans
___Private (Specify company)_____

Do you have any prescription drug coverage or discount assistance of any kind? Y___ N___

If yes, please specify what kind. _____

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FINANCIAL INFORMATION:

(Any of the following documents listed are acceptable as proof)

HOUSEHOLD SIZE _____ (include number of people who contribute to or are dependent on cancer patient's household income.)

HOUSEHOLD INCOME:

(Please select any options below that apply to you)

_____SALARY/WAGES: _____ (proof of income should be for the previous 30 day period and should be for all who contribute to or are dependent on the cancer patients' household income.) Choose one of these options as proof of income.

___One month consecutive documentation including pay stubs.
___Latest Bank Statement
___ Pay stub with year-to-date income
___ Letter on company letterhead
___Notarized statement from employer

_____SELF –EMPLOYMENT INCOME:

___ 1099 Form including Schedule C from the most recent tax return
___ Copy of the most recent paycheck or paycheck stub

_____SOCIAL SECURITY RETIREMENT

___Benefit statement for current year
___Copy of most recent bank statement showing direct deposit
___ Copy of most recent check or check stub

_____SUPPLEMENTAL SECURITY INCOME

___Benefit statement for current year
___ Copy of most recent bank statement showing direct deposit
___ Copy of most recent check or check stub

_____SOCIAL SECURITY DISABILITY

___ Pending notification after applied
___Benefit statement for current year
___ Copy of most recent bank statement showing direct deposit
___ Copy of most recent check or check stub

_____UNEMPLOYMENT BENEFITS

___ Unemployment award letter on company letterhead indicating the period covered
___ Copy of most recent unemployment check or check stub

_____VETERAN BENEFITS

___Benefit statement for current year
___ Copy of most recent bank statement showing direct deposit
___ Copy of most recent check or check stub

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____ALIMONY/CHILD SUPPORT

___Court award letter indicating amount and time period covered
___Child Support Enforcement Agency letter
___ Letter from attorney stating amount and time period covered
___Copy of one month's check or check stub

_____PENSION/RETIREMENT

___Benefit statement for current year
___ Copy of most recent bank statement showing direct deposit
___ Copy of most recent check or check stub

____OTHER

___ Benefits statement
___ Award letter
___ Bank statement from payer/source
___ Copy of checks
___ Judgment statements

By my signature, I certify that all the information on the application is correct and complete. I do not have sufficient financial resources to pay for medical treatments or medications related to my cancer.

_____ ____ Date_____

Cancer Patient Signature

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. To the best of my knowledge, the cancer patient has insufficient funds to be able to receive medical treatment or medications or pay medical bills resulting from high costs of medical treatments and medications.

_____ Date _____

Witness

Application must include a copy of a current tax return.

After completing the application, please mail to the following address:

Angel Fund Foundation, Inc.
P.O. Box 6232
Texarkana, TX 75505

or you can FAX it to 866-824-4930. If you have any questions, call 903-791-0349.

Your application will be processed and you will be contacted if any more information is required. You will receive written notice of approval or disapproval within thirty days.

Angel Fund Distribution Guidelines

We are a small organization with limited funds, but we are willing to work with you and all organizations as long as funds are available.

1. We only pay bills submitted and approved with the application.

2. We do not pay outstanding bills before diagnosis or bills for the diagnosis. Approval is conditioned upon available funds and Board approval.

3. When the approved funds run out, you may reapply, but subsequent requests might not be accepted or approved.

4. These guidelines must be signed and dated by the applicant before the application can be processed.

5. By signing below, applicant hereby releases Angel Fund Foundation, Inc. from any and all liability that may arise from applicant's participation in this organization's financial assistance. The applicant realizes that their patient information may be faxed, emailed, and/or mailed to an unsecure site.

   It is understood that the results of the approval will be released to the applicant, the physician, clinic, treatment center, hospital, and the Board of Directors of Angel Fund Foundation, Inc. Angel Fund Foundation, Inc. will use reasonable efforts to maintain the confidentiality of the data submitted by the applicant. The applicant understands that their name will be disclosed to the Angel Fund Foundation, Inc. Board of Directors and selected volunteers as well as to any physician and/or medical facility that may provide health care and/or treatment. I have read this form and understand its content.

Signature of the Applicant: _____

Date Signed: _____ Date of Diagnosis: _____

Revised July 2013

ANGEL FUND FOUNDATION, INC.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH IMFORMATION
FOR PAYMENT TO HEALTHCARE PROVIDERS
PRIVACY PRACTICE NOTIFICATION

I, _____, understand that as part of my financial assistance for my cancer treatment, Angel Fund Foundation, Inc. maintains paper and or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future treatment. I understand this information serves as:

. A means of communication among the many professionals who contribute to my care,
. A source of information for applying my diagnosis and surgical information to my bill,
. A means by which Angel Fund Foundation, Inc. can verify that services billed were actually provided.

I hereby consent to Angel Fund Foundation, Inc.'s use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to the payment of my health care and treatment.

Angel Fund Foundation, Inc. is authorized by this form to disclose or discuss my protected health information with the following named people:

Name & Relationship Phone # Home & Cell

_____

_____

_____

_____

_____

I understand that I have the right to revoke anyone listed on the authorization at anytime by submitting a new form.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information in the possession of ANGEL FUND FOUNDATION, INC. concerning my illness, treatment to any medical facilities requesting such information needed for the purpose of assisting in paying for my cancer treatment.

_____

Patients Printed Name Date

_____

Patient's Signature

_____

Witness