Bettie Jane Cancer Foundation

P.O. Box 225 Braddock Heights, MD 21714

Serving Frederick County & Washington County Maryland

Patient Section

(Note: This section to be completed by the patient / person requesting financial assistance)

Application Date: _____

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

U.S. Citizen? Yes / No (If No, you are not qualified at this time)

Disabled? Yes / No Gender: Male / Female

Employer: _____

If the patient is a minor, name of parent of guardian: _____

Marital Status: Single / Married / Divorced

If married, Spouses information:

Full Name: _____

Employer: _____

Phone Number: _____

Household Members: _____

Revised Sept 2016

Have you applied for Medical Assistance in the past six months: (If yes, provide the denial letter) _____

Total Household Monthly Income:

Salary		Social Security Income	
Pensions		Short Term Disability	
Unemployment		Public Assistance	
SS Disability			

(Note: While no specific income guidelines are set, the Foundation reserves the right to award to those in the greatest of need financially. Please attach documentation to support financial hardship.)

Are you receiving assistance/have applied to other organizations for help? If so, who? Approved or Denied?

Health Insurance Information

Does the patient have health insurance? _____

If yes, please provide the following information:

Name of Provider: _____

Deductible Amount: _____

Co-Payment Amounts: _____

Prescription Coverage: _____

Doctor's Office and Pharmacy Information

Office Name: _____

Name and Number of Nurse or Patient Advocate at office: _____

Pharmacy Name and Number: _____

Financial Needs

Insurance Premiums	
Pharmacy Drug Costs	
Other (please explain)	

The Information provided in this application is truthful and accurate to the best of my knowledge. Falsification can lead to prosecution.

_____

Signature of Applicant

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Medical Information

(Note: This section to be completed by your Oncology Doctor, Nurse, Social Worker, or Hospital ACS Patient Navigator Only)

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone and Fax Numbers: _____

Date of Patient's Diagnosis: _____

Primary Cancer: _____

Current Stage: _____

New or Recurrence: _____

Is the Patient undergoing active treatment? If no, indicate the frequency of follow up (yearly, every 6 months, other) _____

Type of treatments received in the past 12 months: (Circle all that apply)

Chemotherapy / Radiation / Surgery / Hormonal / Bone Marrow / Stem Cell Transplant / Palliative Care

Name and Title of the Person Completing this Section: _____

Signature of Person Completing this Section: _____

For Internal Use Only

Application # _____

Date Approved/Denied _____

Application Check List:

- 3 Page Completed Application
- Copies of all bills requesting payment
- Taxes from previous year
- Letter from employer stating A) Not working at all and date of last work OR B) Number of hours currently working vs. number hours previously worked before treatments