Jamestown Families Cancer Care

Application for Financial Assistance

The example DOCTOR'S LETTER that is found on our website stating you are in ACTIVE TREATMENT MUST accompany this application.

Please use the TAB button when filling out.

Patient Name: _____ Date of Birth _____

Address: _____

City/State/Zip: _____

Telephone Number: □ Home: _____ □ Cell _____ (Check primary)

Email: _____

Number of children in household under the age of 19: _____

School District: _____

Place of Employment: _____

Emergency Contact: _____
Name **Phone Number**

INSURANCE INFORMATION (please check the box/es and list the medical insurance company if applicable)

□ Private Insurance Company Name: _____

□ Medicare

□ Medicaid

REQUEST FOR ASSISTANCE (check all that apply)

□ Groceries – grocery card

□ Gas – gas card (need to submit a travel log to receive fuel reimbursement)

□ Cancer Drugs – IHS

I, _____, hereby authorize the Jamestown Families Cancer Care to contact my
Patients' Printed Name

cancer physician/treatment center to validate treatment if needed.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Individual Completing Application Date

Date application received _____ Initials _____ Date application approved Initials _____

□ Medical letter with application is required for processing

Eff. 3/29/25 _____

HIPAA AUTHORIZATION AND WAIVER

Now comes the undersigned, _____, with a residence address of _____, stating that I am an applicant for receiving cancer care financial assistance from Jamestown Families Cancer Care, Inc. ("JFCC"), an Ohio non-profit corporation, and am providing personal healthcare information to this organization directly and through my physicians and other medical professionals as part of that application process.

I am willingly providing this information to JFCC directly about my cancer diagnoses, care, medicines, and treatments based upon my medical records, the professional opinions of my physicians and medical staff, and related healthcare organizations.

In addition, in order for JFCC to receive and process this information on my behalf relating to such application, it is necessary for me to execute this Health Insurance Portability and Accountability Act of 1996 ("HIPAA") authorization and waiver in favor of JFCC to allow its representative to communicate with me directly and the other persons referenced herein.

Therefore, for the reasons and purposes set forth above, I hereby authorize any physician, medical personnel, hospital, health care institution, pharmacist, or any other medical service provider, to release any and all relevant information to the determination of my cancer diagnoses, care, medicines, and treatments, to:

Attorney-In-Fact:	**Jamestown Families Cancer Care, Inc.**,
	c/o _____, _____
Address:	P.O. Box 35
	Jamestown, Ohio 45335
Phone No.:	_____

upon the presentation of said documents to which this form is attached as an Addendum to the above-mentioned medical providers.

This authorization and waiver are fully understood and are made voluntarily. I understand I have the right to revoke this authorization and waiver at any time. I further understand if I revoke this authorization and waiver, I must do so in writing.

In addition, this authorization to release information and waiver of privacy under United States HIPAA protection laws specifically includes an authorization of any financial institution or medical provider to communicate with and release information to the above duly appointed Attorney-In-Fact to obtain information, documents, medical records, and/or financial records in order to comply with additional federal and state laws and regulations as necessary.

I understand the purpose and effect of this document and sign my name to this HIPAA authorization and waiver form on _____ _____, 202__, at _____, Greene County, Ohio.

_____
[Print Name] _____

STATE OF OHIO)
) ss.
COUNTY OF GREENE)

BE IT REMEMBERED, that on the _____ day of _____, 202__, before me, a Notary Public in and for said State, personally came _____, to me known to be the person described in the foregoing document, and who acknowledged the signing thereof to be their voluntary act, for the uses and purposes herein mentioned.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal, on the day and year last above mentioned.

_____
Notary Public

This Instrument Was Prepared By: David P. Suich, Esq., McNamee Law Group, LLC, 2625 Commons Blvd., Beavercreek, Ohio 45431, Tel. (937) 427-1369, dsuich@mcnameelaw.com