Patient Assistance Application

Name (First, Middle, Last): _____

Preferred Name: _____ Male: ___ Female: ___ Are you a Veteran: Y or N

Address:_____

City:_____ County:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Last 4 digits of SS #:_____

Home #:_____Cell #:_____Work #:_____

Email Address:_____

Ethnic Background: White__ African Amer.__ Hispanic__ American Indian__ Asian__ Multi-Ethnic__ Other__

Church Affiliation: _____ Home Congregation: _____

Married: Y or N Spouse/Partner Name:_____ Age:_____

Cell Phone:_____ Work Phone:_____

Email Address:_____

Additional Contact:_____ Relationship:_____

Home Phone:_____Cell Phone: _____Work Phone:_____

Email Address:_____

Number of residents living in household: _____

Please list names, ages, and ethnic backgrounds of all members living in home:_____

_____

_____

_____

Do you currently have a fixed income? Y or N

Has there been a loss of wages due to your current cancer diagnosis: Y or N

Patient's Employer:_____ Income:_____

Spouse/Partner's Employer:_____ Income:_____

Other Income Sources:_____

Total Monthly Household Income: _____

Are you currently receiving Food Stamps? Y or N Monthly Amount:_____

Do you currently have health insurance? Y or N

Insurance Provider:_____ Co-Pay:_____

Deductible:_____ Prescription Coverage: Y or N

Pharmacy:_____ Phone:_____

Cancer diagnosis (type of cancer): _____

Stage of cancer: _____ Date of diagnosis: _____

Please share how you were diagnosed:_____

_____

_____

Primary Care Physician:_____

Phone:_____ City:_____

Radiation Oncologist:_____ Phone:_____

Oncology Group:_____ City:_____

Medical Oncologist:_____ Phone:_____

Oncology Group:_____ City:_____

Please describe how your current cancer diagnosis has affected your financial situation:

_____

_____

Please list all your monthly expenses below. If additional space is needed, please attach separate sheet to application:_____

_____

_____

_____

Please list your greatest need: _____

_____

_____

How were you referred to Sherry's Hope?_____

_____

_____

I give Sherry's Hope permission to obtain and share my protected healthcare information in coordination with possible benefits from Sherry's Hope. I understand that by signing this form it does not guarantee financial assistance and it also releases Sherry's Hope from any form of liability.

Signature:_____ Date:_____

Printed Name:_____

Relationship to Patient:_____

***** Please include a letter of diagnosis and treatment plan from your oncologist.*****
*****Incomplete Forms will not be processed.*****

Sherry's Hope does not discriminate based on any information received.

P.O. Box 8, Lebanon, TN 37088 615-925-9932 help@sherryshope.org

Sherry's Hope Fax Number: 1-615-784-4061

Sherry's Hope is a 501 (C) (3) of the Internal Revenue Code.

Permission/HIPAA Release Form

I, _____ give Sherry's Hope permission to obtain my protected health care information in coordination with possible benefits.

Please Print Clearly

Full Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

County:_____ Last 4 Digits of Social Security #:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Signature:_____ Date:_____

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