SHERRY'S HOPE

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 understand that by signing this form it does not guarantee financial assistance and it also releases Sherry's Hope from any form of liability. I understand that if approved, assistance given by Sherry's Hope is temporary and may change or be terminated based on availability of funds, my treatment plan, health status, or changes in Sherry's Hope policies and procedures as determined by the Sherry's Hope Patient Assistance Board of Directors.

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.

SHERRY'S HOPE

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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