Jay County Cancer Society Client New Client Form

Office Address: 227 N. Meridian Street, Portland, IN 47371

Mailing Address: P.O. Box 617, Portland, IN **47371**

Phone: 260-726-8110

Email: JayCancer614@gmail.com

Web: www.JayCountyCancersociety.org

CLIENT INTAKE FORM

First name: _____ Last name: _____ Date of Birth: _____

Address: _____ City, State and Zip: _____

Phone number: Home/Cell: (_____) _____Email Address:_____

Date of Birth: _____If patient is a minor (under 18) name of parent or guardian: _____

Sex: ____ Male ____Female Ethnicity: ____White ____African American ____Latino _____Asian ____Other

Caregiver /Emergency Contact: _____

How did you here about Jay Co. Cancer Society_____

Medical Information requirements

Provide printed medical document of diagnosis or you can email documentation to JayCancer614@gmail.com

Date of Diagnosis: _____Primary Cancer: _____ Current Stage: _____

_____New diagnosis_____Recurrence**Is the patient in current treatment?**_____Yes _____No

If not in active treatment, please indicate the frequency of follow up: ____Yearly ____Every six months ____Other

Please indicate type of treatment(s) received in past twelve months (check all that apply):

___Chemotherapy ___Radiation ___Surgery ___Hormonal ___Palliative Care ___Bone Marrow/Stem Cell Transplant

Will you be transporting yourself to treatment Y/N If not, who will be transporting you_____

*****Please complete all fields above*****

MD name: _____ Hospital/Clinic: _____

Address: _____ City, State and Zip: _____

Phone: (_____) _____Email: _____

Name & title of person completing this section, if different than above (please print): _____

Phone: (_____) _____Email: _____

Your relationship to person applying for help: ____Doctor ____Nurse ____Social Worker _____ACH Hospital Patient Navigator

PATIENT'S NAME: _____ DOB: _____

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE

HEALTH INSURANCE INFORMATION

Does the patient have health insurance: Yes/NO

If yes, please indicate the type of insurance (check all that applies):

____Private insurance ___Medicaid ____Medicare ____Medicare plus Medigap ____Charity care ____VA program

Are prescription drugs covered? Yes/No Annual Deductible $_____

HOUSEHOLD FINANCIAL INFORMATION

(Information has no effect on eligibility for Cancer Services, but it is needed for grant reporting purposes.)

Is the patient currently employed?____Yes____No

Are you a Veteran? Yes/No

Number of people in household:____ Annual Income_____

FAMILY INCOME AMOUNTS (please include all that apply)

_____Social Security (Retirement)_____Salary_____Pension

_____Unemployment_____Short Term Disability_____Public Assistance

_____SSI_____SSD (Disability)_____Family/friend support

_____Other (please specify) _____

FINANCIAL ASSISTANCE NEEDS

(check all that apply):

_____Transportation _____ Cancer-related mediations _____ Mileage____ Wigs & Mastectomy ____

_____Lymphedema Supplies _____Co-pays _____ Medical Supplies_____ Educational Resources

How do you feel Jay County Cancer Society can best help you?

_____

Patient Signature

_____Date:_____

Thank you

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Jay County Cancer Society will review this information and contact the person requesting financial assistance.

ALL information is strictly confidential and is for Jay County Cancer Society's use only.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

Authorization for Use or Disclosure of Information

For Purposes requested by Jay County Cancer Society

I, _____, hereby authorize the Jay County Cancer Society to:

1. Access my personal medical records from my physician(s) and authorize the Jay County Cancer Society to receive copies of those records
2. Use the following protected health information and/or
3. Disclose the following protected health information from the Jay County Cancer Society

This protected health information is being used for the following purposes:

1. Patient's demographic information, required by the Jay County Cancer Society, to contact the patient and perform evaluation.
2. Gather required documents for billing purposes.

This authorization shall be in force and in effect until the event that related to the patient of the purpose of disclosure of this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Attn: Jay County Cancer Society. I understand that a revocation is not effective to the extent that the Jay County Cancer Society has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law or state to the extent the state law provides greater access rights.
- Refuse to sign this Authorization.

The Jay County Cancer Society will not condition my treatment on whether I provide authorization for the requested use or disclosure, except for the following circumstances:

- When the provision of health care by the Jay County Cancer Society is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Jay County Cancer Society from a third party (if applicable).

_____ _____

Signature of Patient Date

_____

Printed name of Patient