CANCERCARE

Dear Applicant,

Thank you for your interest in East Texas Alliance of Hope (ETxAH) Financial Assistance Program. ETxAH is a non-profit organization designed to assist with the financial burden many individuals are faced with having been given a cancer diagnosis.

Enclosed is the ETxAH application for assistance and instructions on how to complete this application. All applications will be brought before a committee and considered no matter the individual or family household income. ETxAH has the right to deny services based on the discretion of the committee. ETxAH does not discriminate on the basis of race, ethnicity, religion, sex, sexual orientation or age. Please note that all applications must be submitted to ETxAH by a referring professional (i.e. your family doctor, oncologist, social worker, or other health care professional who is involved in your care). Please read the instructions very carefully and fill out the application completely. ETxAH will require you to provide financial documentation to verify your income and expenses. ETxAH will use the provided information to gain a complete understanding of your situation.

Please note, incomplete applications submitted by clients will not be reviewed which will delay any funds being released. Also, this application is not a guarantee for financial assistance and you remain responsible for your account balance.

Referring professionals are asked to print and mail this application to the address below or visit our webpage at www.etxcancerallianceofhope.org and submit an application.

Mailing Address
East Texas Alliance of Hope
P.O. Box 151114
Lufkin, TX 75915

Physical Address
East Texas Alliance of Hope
513 S First Street
Lufkin, TX 75901

Thank you again for your interest in East Texas Alliance of Hope. If you have questions or concerns please give us a call at 936-899-7307 or email ashley@etxcancerallianceofhope.org

In Hope,

Ashley Berry
East Texas Alliance of Hope
Founder and CEO

East Texas ALLIANCE of HOPE

APPLICATION INSTRUCTIONS

ELIGIBILITY & GUIDELINES

Eligibility Requirements:

APPLICANTS MUST MEET THE FOLLOWING QUALIFICATIONS TO BE CONSIDERED FOR FINANCIAL ASSISTANCE.

To determine if you qualify, we require the following supporting documentation:

- Verification of Texas Residency in Angelina or Nacogdoches County
- Verification of Income and Assets
- Cancer Diagnosis certified by a healthcare provider
- Be in active treatment or within a three-month period of cancer treatment. Active treatments include chemotherapy, radiation therapy, or cancer related surgeries
- Patient declines active treatment and is admitted to a hospice service

Application Instructions:

1. Have a referring healthcare professional fill out and sign the professional recommendation
2. Fill out the client application completely
3. Provide supporting documentation from the document list
4. Submit application and supporting documentation

Email Application
info@etxcancerallianceofhope.org

Mail Application
East Texas Alliance of Hope
P.O. Box 151114
Lufkin, TX 75915

Submit in Person
East Texas Alliance of Hope
513 S First Street
Lufkin, TX 75901

It is important that you complete this application and return it with all required documentation within 15 days. If you have difficulty completing this application or if you have additional questions, please call ETxAH, Monday through Friday, from 9am to 4pm at 936-899-7307.

LOCAL SUPPORT for LOCAL PEOPLE

East Texas ALLIANCE of HOPE

HEALTHCARE PROFESSIONAL RECOMMENDATION

TO BE FILLED BY A HEALTHCARE PROFESSIONAL

PATIENT FULL NAME: _____ DATE OF BIRTH ____/____/____

ADDRESS: _____ PHONE _____-_____-_____

MEDICAL DIAGNOSIS: _____

WHAT ARE THE CIRCUMSTANCES CAUSING THIS FAMILY TO SEEK ASSISTANCE?

_____

_____

_____

_____

_____

IS THERE ANY INFO YOU CAN PROVIDE THAT WOULD ASSIST US IN HELPING THIS CLIENT?

_____

_____

_____

_____

_____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AGREE WITH THE FUNDING NEED.

REFERRING HEALTHCARE PROFESSIONAL NAME _____ DATE ____/____/____

ORGANIZATION _____ PHONE _____-_____-_____

SIGNATURE

_____

PLEASE EMAIL THIS FORM TO INFO@ETXCANCERALLIANCEOFHOPE.ORG

OR

MAIL TO PO BOX 151114 LUFKIN, TX 75915

East Texas ALLIANCE of HOPE

DOCUMENT LIST

Client Financial Assistance Application Document List

IDENTIFICATION: (ONE REQUIRED)

1. ____Valid Texas Driver's License w/photo
2. ____Valid Texas Identification w/photo
3. ____Valid current U.S Passport or Passport Card w/photo
4. ____Valid current Permanent Resident Card (Green Card) w/ photo
5. ____Other valid current government issued photo ID

RESIDENCE PROOF: (ONE REQUIRED)

1. ____Deed or Property Tax Assessment in Applicant's Name
2. ____Lease in Applicant's Name
3. ____Military ID w/Texas Address
4. ____Non-Leasing Resident in Rental Unit (Notarized Letter)
5. ____Non-Leasing Resident in Homestead (Notarized Letter)

RESIDENCE INDICATOR: (TWO REQUIRED)

1. ____Valid Texas Driver's License or identification card w/photo
2. ____Texas Voter Registration Card
3. ____Bank Statements w/TX address - 6 most recent months (patient / spouse)
4. ____Unemployment compensation, Food Stamps, w/ TX address (patient / spouse)
5. ____Utility Bills in applicants name w/ TX address (Electric, Natural Gas, Water, Cable)
6. ____Letter/Card for a Texas County Indigent HealthCare Benefits (past 6 months w/TX address)
7. ____Notarized letter from Texas employer (on company letterhead) showing dates and location of employment
8. ____Proof of Texas public or private school or university enrollment for past six months

ASSETS: (ALL THAT APPLY)

1. ____Bank Statements; ALL Accounts (3 most current months) (patient / spouse)
2. ____If NO BANK ACCOUNT (complete Verification of No Bank Account Form)
3. ____Certificate of Deposit Statements (3 most recent months) (patient / spouse)
4. ____County Tax Appraisal for property other than Primary Residence
5. ____Securities Statements from last quarter (401K, Money Market, Stocks, Bonds, Etc) (patient / spouse)
6. ____Mortgage Statement for property other than Primary Residence
7. ____Most recent trust bank statement

INCOME: (ALL THAT APPLY)

1. ____Social Security (SSI or SSDI) Earning Statement or Social Security Award Letter (most recent) (patient / spouse)
2. ____Payroll Complete Check Stubs (3 most recent months) (patient / spouse)
3. ____Unemployment Compensation (patient / spouse)
4. ____Texas Workforce Wage History Report for (patient / spouse)
5. ____Family Support Letter

OTHER: (ALL THAT APPLY)

1. ____Proof / Verification of Current Insurance
2. ____County Indigent HealthCare Eligibility Determination Letter/ Card (most current)
3. ____MedData Eligibility Assistance Program (required call 713-563-0280)
4. ____Divorce Decree / Death Certificate
5. ____Proof of Health Insurance Marketplace Eligibility Determination

LOCAL SUPPORT for LOCAL PEOPLE

Cancer Care Client Intake Form

513 S. First St., Lufkin, TX 75901
Phone: 936-899-7397

Please **print clearly** and complete both sides of this form. Your personal information is kept confidential. *Services are provided free of charge for qualifying cancer patients and are made possible by the generosity of local donors and foundation grant funding.*

PROFILE: DATE:_____

Name:_____ Male____ Female____ Birth Date:_____ Age:_____

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

Cell Phone: (___)_____ Home Phone: (___)_____ SS#_____

Email:_____ Patient Preferred Contact Method:____Home ____Cell Email__

East Texas Alliance Of Hope will occasionally need to call patients, and we wish to ensure your privacy regarding your treatment or services at our organization. If we are unable to reach you by phone, please indicate where it is appropriate to leave a voice message for you (check all that apply:

____ Voice Mail ____ With family member. ____ Work ____ Never leave messages. ____Text Message

Patient Demographic Information

Marital Status: Married ____ Single ____ Divorced _____ Widowed____ Divorced_____ Widowed____

If married, spouse name:_____ Spouse Phone_____

_____(Initial) **Permission granted to release any medical information to Spouse OR Disclosed Individuals**

Emergency Contact: _____ Relationship to Client _____

Emergency Contact Phone:_____ (Initial) **Permission granted to release information.**

Contact 1 Name:_____ **Contact 2 Name:**_____

Phone:_____ **Phone:**_____

Relationship_____ **Relationship**_____

____ (Initial) Permission granted to release information ____**(Initial) Permission granted to release information**

Patient Preferred Language: _____English ____Spanish ____Other_____

White ____ Black/African American ____ Hispanic ____ Asian____ Alaska Native ____ American Indian____
Refused to Report/ Unreported____ Other: _____

NOTICES OF OF PRIVACY PRACTICES

_____(Initial) I acknowledge that I have been aware of the "Notice of Privacy Practices" posted by East Texas Alliance of Hope. This notice describes the ways in which the practice may use and disclose my healthcare information for its services, payments, healthcare operations, and other described and permitted uses and disclosures.

I understand I may request a copy of this notice at any time. I may contact the East Texas Alliance of Hope at (936) 899-7307 should I have any questions, comments, or complaints. To the extent permitted by law, I consent to using and disclosing my information for the purposes described in the Notice of Privacy Practices.

CONSENT TO HEALTHCARE COMMUNICATIONS

_____(Initial) I consent to receive healthcare communications at the above list number(s)/ email address(es) for primary and alternative contact information for the purpose of appointment scheduling and reminders. I understand this includes voicemail messages.

_____ _____
Patient Signature Date

DISCLOSURE TO FAMILY AND/ OR FRIENDS

I give permission for my Protected Health Information, Medical Records, or any information obtained to be disclosed for the purposes of communicating results, findings, and care decisions to the person listed below.

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Patient Signature **Date**

PHYSICIAN AND DIAGNOSIS: **I understand East Texas Alliance of Hope may need to speak with my medical provider, social worker, or other support staff and grant permission for this contact:

1. Physician/Oncologist_____
2. Diagnosis/Type of Cancer _____Stage_____ Date of Diagnosis _____
3. Are you receiving: Chemo _____Radiation _____Date therapy began or will begin _____

***EMPLOYMENT AND FINANCIAL INFORMATION: ***

Are you currently employed? ____Yes ____No

If No, were you employed before diagnosis? ____Yes _____No Are you on medical leave? _____Yes _____No

Number of people in household: _____ *Please list others besides yourself living in the home.*

Name: _____ Age: _____ Relationship to you: *(spouse, child, etc)*_____

Name: _____ Age: _____ Relationship to you: *(spouse, child, etc)*_____

Name: _____ Age: _____ Relationship to you: *(spouse, child, etc)*_____

Name: _____ Age: _____ Relationship to you: *(spouse, child, etc)*_____

TOTAL MONTHLY FAMILY (HOUSEHOLD) INCOME : $_____ (Including Spouse)

Proof of income is required for ALL Assistance programs.

Wages/Employment $ _____ Social Security $_____ Pension $ _____

Public Assistance $_____ Short-term Disability $ _____ SSD or SSI $ _____

Unemployment $_____ Family/friends $_____ Other $ _____

Health Insurance

1. Medicare: Part A___ Part B___ Part D___ No ___ Medicaid: Yes____ No____ Provider: _____
2. Have you applied at Texas Workforce Solution? Yes_____ No_____
3. Other insurance _____ Are you a Veteran? Yes _____ No _____
4. Do you have any Rx drug plan? Yes ___ No___ Name of drug plan _____

What do you hope to get out of your visit today?

_____
_____
_____

What are your most important concerns? Please List in order of importance._

1._____
2._____
3._____
4._____

HOW DID YOU HEAR ABOUT CANCER SERVICES:

_____DOCTOR _____WEBSITE FAMILY_____ FACEBOOK_____ NURSE_____ FRIEND_____

I ATTEST THAT THE INFORMATION PROVIDED IS TRUTHFUL TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT GIVING FALSE INFORMATION WILL RESULT IN LOSS OF ELIGIBILITY OF SERVICES:

Patient's Signature_____ Date_____

or Authorized representative_____ Date_____

****

FOR OFFICE USE ONLY:

Date form received: _____
Services Approved: _____
Approved by: _____

Assistance or program requested: *Please check all that apply.*

This list will help you identify patient concerns at the initial visit and at each follow-up visit. It will help us develop a plan of action, including referrals to appropriate organizations.

___ Nutritional Supplements (Boost, Ensure, Instant Breakfast, etc.)
___ Medical Equipment (Wheelchairs, walkers, bedside commodes, shower chairs, etc.)
___ Medical Supplies (dressing, tapes, incontinent supplies, etc.)
___ Wigs and/our Mastectomy Items (wigs, hats, turbans, breast prostheses, bras)
___ Support Services: Journals, support groups, community resources,
___ Other

Barriers to care

___ Inadequate or lack of insurance coverage
___ Difficulty paying bills
___ Confusing financial paperwork
___ Citizenship problems/ undocumented status.
___ Pre Certification problems
___ Need financial assistance from
___ Need for prescription assistance
___ Loss of Transportation

Transportation to and from treatment

___ Public transportation needed
___ Other_____
___ Private transportation needed
___ Transportation loss

Physical needs

___ Child/ Elderly care (CCS/ Salvation Army Adult Daycare)
___ Housing/ housing problems (Deep East Texas Council of Government/ Section 8)
___ Food, Clothing, other physical needs (SNAP(Supplemental Nutrients Assistance Program/ Food Bank
___Prothesis, wigs, ect.
___ Vocational Support (jobs skills, employment skills) Texas Workforce Commission/ Job corps
___ Extended care needs: home care, hospice, long-term care
___ Other: _____

Communication/Culture Needs

___ Primary language other than English
___ Inability to read/write
___ Poor health literacy
___ Cultural barriers (i.e., effect on lifestyle choices)
___ Other:_____

Treatment Compliance Issues (Missed Appointments, etc.)

___ Needs help with obtaining a second opinion (if desired)
___ Mental health services needed
___ Does not understand treatment plan and/or procedures
___ Needs to talk to provider (physicians, nurse, therapist, etc.,
___ Wants more information about:_____
___ Other_____

Supportive Services for Needed

___ Social Worker
___ Clergy
___Look Good Feel Better
___Second Opinion Services
___Nutritionists
___ Support Partner
___ Support Group
___ Financial counselors

Plan of Care and Follow up:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT NAVIGATION INTAKE FORM (CONTINUED)

COMMENTS:

_____

_____

_____

_____

_____

_____

TRACKING TOOL

Refer to POTENTIAL PROBLEMS/ BARRIERS TO CARE to explore patient concerns. Record the results of each intervention or visit with the patient.

****

FOR OFFICE USE ONLY:

Date form received: _____

Services Approved:_____

Approved by: _____

East Texas Alliance of Hope

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before deciding whether to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we make of your protected health information.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information for treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had the full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: _____
Parent/Legal Guardian Name: _____
Signature: _____ Date: _____
Relationship to Patient: _____

For office use only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communication barriers prohibited obtaining the acknowledgment
- ▫ Other (please specify)

_____

East Texas Alliance of Hope

Confidentiality Statement

Carefully read the following statement. If you are able to comply, please sign below:

The East Texas Alliance of Hope is committed to the safety and welfare of its clients. The organization is also committed to the confidentiality of all information regarding its clients as a means of ensuring their safety.

Confidentiality is defined as the assurance that access to information regarding any client shall be strictly controlled, and that any violation of such control shall be a breach of faith. Confidential information shall include, but in not limited to:

1. Communications, information, and observations made by and between or about adult and child clients, staff, volunteers, student interns and board members.
2. Addresses of employment, residence, and family addresses of clients, staff volunteers, student interns, and board members.
3. Names of clients, staff, student interns, and volunteers, unless written permission is provided by the individual approved by the Executive Director.
4. Photographs taken of clients, staff, or volunteers.
5. Board members will not use their position on the Board of Directors to obtain or access confidential client information.

By signing this agreement, you agree to never release confidential information, either over the phone or in person, about ETxAH and its clients without the expressed permission of the Executive Director or a designated staff member.

I have read the Agreement of Confidentiality and agree to abide by its conditions of confidentiality. I understand that these conditions apply to me and continue to be binding on me when I leave or am no longer associated with the organization and that a violation may be grounds for civil liability and may also be grounds for termination of volunteer status, board memberships, employment, or services.

_____ _____

Signature Date

_____ _____

Witness Signature Date

East Texas Alliance of Hope
513 S. First St
Lufkin, TX 75901

Authorization for Disclosure of Protected Health Information to Family Members and Specified Friends

Patient Name: _____ **Pt.#**_____

I authorize **East Texas Alliance of Hope** to disclose my protected health information to the following:

Name	Relationship	Telephone #
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

This authorization shall be in force and effective until my death or revocation at which time this authorization to disclose this protected health information expires.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 513 S. First St, Lufkin TX 75901. I understand that a revocation is not effective to the extent that **East Texas Alliance of Hope** has already relied on the consent for disclosure of the protected health information.

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

_____ _____

Client Date

_____ _____

Primary Care Giver/ Authorized Representative Date

_____ _____

East Texas Alliance of Hope Representative Date