1 cancer source Assistance Program

Cancer1Source Assistance Program
50 Whittemore St., Gloucester, MA 01930
Phone: 844-361-2406 Fax: 888-246-6527

GENERAL INFORMATION

This application is for Massachusetts residents participating in any of the Cancer 1 Source patient assistance programs which are:

- Co-Pay Assistance Program provides up to $150.00/pp/per year for the following:
  - Cancer Genetic Testing (Co-pay___ Deductible___ Out-of-pocket___ or Voucher*)
    **Voucher provided by medical provider*
  - Cancer Genetic Counseling (can be obtained by someone with a predisposition to cancer)
  - Hospital Bills
  - Medication Co-pay
  - Durable Medical Equipment
  - Gas Card ($25.00, up to $100.000/year if no other co-pay assistance from CRF)
  - Mom's Meals___ (per CRF website) and Meal Grocery Cards___

- Co-Pay Assistance Program provides up to $150.00/pp/per year. Co-pays include deductibles or out-of-pocket expenses.

Please be sure to answer all the questions, sign and submit all the required documentation. Send the application to Cancer1Source Assistance Program, 50 Whittemore St., Gloucester, MA 01930 or fax it to 888-246-6527. Incomplete applications will be returned. If you resubmit your completed application after 2 weeks it will be rejected.

PRODUCT(S)/PROGRAMS I AM APPLYING FOR

Co-Pay Assistance Program provides up to $150.00/pp/per year for the following:

- ☐ Cancer Genetic Testing
- ☐ Cancer Genetic Counseling
- ☐ Hospital Bills
- ☐ Medication Co-pay
- ☐ Durable Medical Equipment
- ☐ Gas Card ($25.00, up to $100.000/year if no other co-pay assistance from CRF)
- ☐ Mom's Meals and Meal Grocery Cards

You may apply to more than one program. There is a limit on the total reimbursement to $150 per person per year.

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PATIENT INFORMATION (All required)

First Name:_____ MI: _____ Last Name:_____

Gender: ☐ M ☐ F ☐ LGBTQ

Street Address: _____

City:_____ State:_____ ZIP Code:_____

Phone Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Email: _____
By providing your email you are giving Cancer1Source permission to contact you this way.

Fax: _____
By providing your FAX you are giving Cancer1Source permission to contact you this way.

HEALTH INSURANCE

I have health insurance: Yes _____ No _____

Insurance Limitation (Check one): Co-pay too high _____ No Insurance _____ Other _____

MEDICAL INFORMATION

I have been diagnosed with cancer: Yes _____ No _____

Gender: Female_____ Male _____ Other_____

Proof of diagnosis is required.
One sentence stating the diagnosis is sufficient
___Letter from physician on office stationery
___Note on prescription pad
___Other

INCOME INFORMATION

Income Maximum for 400% of Federal Poverty Level

Household Size	Where You Live		
	48 Contiguous States and D.C.	Alaska	Hawaii
1	$54,360	$67,960	$62,520
2	$73,240	$91,560	$84,240
3	$92,120	$115,160	$105,960
4	$111,000	$138,760	$127,680
5	$129,880	$162,360	$149,400
6	$148,760	$185,960	$171,120
7	$167,640	$209,560	$192,840
8	$186,520	$233,160	$214,560

For each additional person in your household, add the following:
48 contiguous states - $18,880 Alaska - $23,600 Hawaii - $21,720

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HIPAA INFORMATION

I, _____ , agree that the information and documents provided in connection with this application are complete and accurate. I agree that I have documentation to support the information submitted in the application if requested.

I agree to immediately inform the Cancer Resource Foundation if my income or insurance status changes during the course of my participation in this Program. I understand that my information will be used by the Program sponsor, Cancer Resource Foundation, for purposes of determining my participation in, and administering the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/provider) or others. I understand a representative from the Program, may contact me for additional information. I authorize and consent to release identifiable information about me including medical, financial and insurance records and information as required for participation in the program. My authorization includes release of information related to my medical conditions and treatment, if required. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and is no longer protected by Federal privacy regulations. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization however this authorization is required for eligibility in this grant assistance program. This consent shall be in effect until revoked by the patient.

Sign Here _____ _____ _____
Patient Signature | Print Name | Date

Signature and date of another person we can disclose info to.

Sign Here _____ _____ _____
Signature | Print Name | Date