



The Ellsworth County Cancer Fund
Assisting families dealing with cancer
APPLICATION

Patient Information:

Name: _____ SS Number: _____
Address: _____ Date of birth: _____
City/State/Zip: _____
Phone (Day): _____ Phone (Eve): _____ Email: _____

Applicant/ Contact Person- if different from patient

Name: _____ Relationship to Patient: _____
Address: _____ Date of birth: _____
City/State/Zip: _____
Phone (Day): _____ Phone (Eve): _____ Email: _____

I have been diagnosed with cancer (or am submitting this application on behalf of a minor who has been diagnosed with cancer) and require assistance with costs associated with my treatment. I hereby give permission to the staff of the Smoky Hills Charitable Foundation and the Greater Salina Community Foundation to contact the parties listed in this application or attachments thereto for purposes of verification.

Date

Signature of Applicant

Please attach the following information to this cover sheet: *(All items must be completed in order to be considered for a grant)*

- A. A brief medical history, including condition of the patient with regard to cancer. (Examples: *When were you diagnosed? What symptoms are you dealing with?*)
- B. A statement from applicant's medical doctor attesting to the medical conditions and necessary treatment. *(The attached form may be used as a release for to give to your physicians. You need to fill out all the information highlighted in yellow and give to your doctor to release the information to the Foundation).*
- C. A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy.
- D. A brief statement telling us why you need assistance. *(Examples: Are you on a fixed income with increased expenses due to your diagnosis? Has the diagnosis caused you to miss extended periods of work or to lose a job?)* Please include a list of expenses, real or projected, that you have incurred due to your cancer diagnosis and tell us specifically what you are requesting help with *(Examples: gas money? Medical bills? Regular bills due to loss of income?).*
- E. A timetable for the expenditure of the grant. *(When do you need to assistance? When do you predict you will use the assistance?)*

Smoky Hills Charitable Foundation
P.O. Box 265
Ellsworth, KS 67439
smokyhills@gscf.org

AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTH DATE	SOCIAL SECURITY NO.
Patient Address		Patient telephone

CHECK ONE:

I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT

X I HEREBY AUTHORIZE ALL OF MY HEALTH PROVIDERS, INCLUDING, BUT NOT LIMITED TO, _____ TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO: **The Smoky Hills Charitable Foundation, an affiliate of the Greater Salina Community Foundation ("GSCF") its officers, directors, and grant-making committees for the purpose of determining the eligibility of the patient for grants administered by SHCF.**

For Treatment date(s): _____

Specify date(s)- this line MUST BE completed

For the following purposes(s) **At the request of patient and for all purposes connected with the above referenced grant request**

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED (Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)			
<input type="checkbox"/> Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected) <input type="checkbox"/> Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records. <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Demographic Information	<input type="checkbox"/>	Cardiac Studies
	<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/>	Physician Progress Notes
	<input type="checkbox"/> Admission History & Physical	<input type="checkbox"/>	Physician Orders
	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/>	Discharge Summary
	<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/>	Nursing Notes
	<input type="checkbox"/> Lab Test Results	<input checked="" type="checkbox"/>	Billing Records or verification of financial need
	<input type="checkbox"/> Imaging/Radiology Reports	<input checked="" type="checkbox"/>	Physician letter to confirm diagnosis.

This authorization shall remain in effect **as long as the above-referenced grant request is pending and while I am receiving the grant** at which time this authorization to disclose the identified health information expires.

I understand that the records to be used or disclosed pursuant to this authorization may contain information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S. A. § 65-6001et seq. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

- Records relating to participation in any federally assisted drug and alcohol abuse program
- Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition
- Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the designated privacy officer of the provider to whom this authorization is sent. (Note: Revocation is not effective for disclosures that have already been made)

Date **Signature of Patient or Authorized Agent/Representative**

Printed Name of Authorized Agent/Representative **Authorized Agent/Representative's Relationship to Patient**

Address of Authorized Agent/Representative **Telephone # of Authoized Agent/Representative**

Date **Signature of Witness**