UNITED WAY
Sandusky County

United Way of Sandusky County
826 West State Street
Fremont, OH 43420
www.uwsandco.org
419.334.8938

United Way Cancer Care Fund Application for Assistance

Dear Sandusky County Resident,

United Way of Sandusky County is pleased to be able to provide assistance to individuals experiencing financial hardship while being treated for cancer. To qualify, please follow the below steps.

- ☐ Complete the attached application (Page 1) and sign the HIPPA Privacy Authorization (Page 2)
- ☐ Have your healthcare provider complete the Physician Authorization for Services section verifying you have a cancer diagnosis and are currently receiving treatment (Page 2)
- ☐ Supply proof of Sandusky County residency using one of the following forms
  - a current driver's license
  - state ID
  - most recent utility bill in your name
- ☐ Submit the above information to the United Way office

If you have any questions or concerns, feel free to call the United Way of Sandusky County office at 419.334.8938.

Sincerely,

United Way of Sandusky County Staff

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CANCER CARE FUND APPLICATION FOR ASSISTANCE

PLEASE CHECK ONE: **DATE:** _____

☐ Initial Application ☐ Re-Application

CLIENT INFORMATION:

Name: _____

Address: _____

City: _____ Zip Code: _____

IS YOUR ADDRESS IN SANDUSKY COUNTY? ☐ Yes ☐ No

Telephone: _____ E-Mail Address: _____

Date of Birth: _____ Marital Status: _____

☐ Employer _____ ☐ Retired

☐ Insurance Company _____ ☐ Medicaid/Medicare

Do you have Prescription Coverage? ☐ Yes ☐ No Are you a Veteran? ☐ Yes ☐ No

Please tell us briefly your need for assistance _____

How did you hear about the Sandusky County Cancer Care Fund? _____

At what facility are you receiving treatment? _____

ADDITIONAL CONTACT PERSON:
*The individual listed will be authorized to pick up or drop off items on behalf of the client.

Name: _____

Relationship: _____ Do you have Power of Attorney? ☐ Yes ☐ No

Address: _____

City: _____ Zip Code: _____

Telephone: _____ E-Mail Address: _____

HIPPA PRIVACY AUTHORIZATION

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act)

Authorization:

I authorize the United Way of Sandusky County Cancer Care Fund to use and disclose protected health information to discuss my care and treatment related to payment of claims to verify such claims submitted are cancer related.

All information on this form is strictly confidential and will be treated as such by the United Way of Sandusky County Cancer Care Fund.

Signature: _____ **Date:** _____

PHYSICIAN AUTHORIZATION FOR SERVICES

Your patient, _____, has applied for services from the United Way of Sandusky County Cancer Care Fund; we require the following information before he/she is able to receive assistance:

Is he/she currently one of your patients? ☐ Yes ☐ No

Is he/she in current cancer *treatment? ☐ Yes ☐ No
*treatment is based upon your professional determination

Diagnosis: _____

Physician Contact Information:

_____ _____
Name Phone Number

_____ _____
Address Fax Number

_____ _____
Signature Date

PLEASE RETURN THIS COMPLETED APPLICATION TO:

United Way of Sandusky County, Inc.
826 West State Street, Fremont, Ohio 43420
Phone: 419-334-8938 ~ Fax: 419-334-8930