



United Way of 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



United Way of Sandusky County

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:

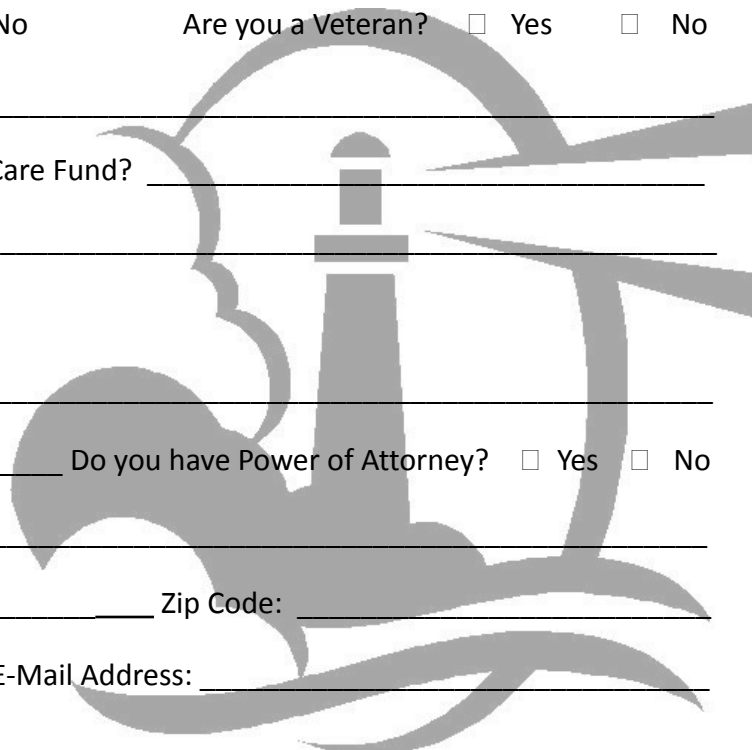
Name: _____

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