Our mission is to assist cancer patients living in Grant County Wisconsin. As applications are submitted, each will be given a case number, allowing as much confidentiality as possible, with only one board member knowing the applicant's name. We are dedicated to being fair to everyone and it is our hope to be able to meet the needs of everyone who applies.

Directions for Completing Packet

1) Application Form

All areas must be completed (except those marked GCCC office use). Please give as much information as possible.
Please sign and date form.

2) Authorization for Disclosure of Health Information

This form must be filled out by the applicant before seeing your doctor. **Leave a completed copy at the doctor's office** to have placed in your medical record and **keep a copy** with you to mail to GCCC with your completed application.

Please let your doctor/nurse know a member from GCCC board will be calling to verify the cancer diagnosis.
Make sure the form is signed at the bottom.

3) Diagnosis Verification Form

This form **must be completed by your doctor**.

Applications are verified and final approval is authorized at the earliest board meeting. The volunteer board meets the first Wednesday of each month. If your application arrives after the first Wednesday of the month, your application will not be looked at until the following month.

<u>All three forms</u> listed above must be returned to the address below:

ATTN: Application Committee
Grant County Cancer Coalition
PO Box 105
Lancaster WI 53813

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Grant County Cancer Coalition
PO Box 105
Lancaster, WI 53813

APPLICATION FORM

Please check:
____ 1st time applying for assistance
____ 2nd time applying for assistance
____ 3rd time applying for assistance

Applicant
Name _____ Phone _____
(please print)
Address _____

_____
(city) (state) (zip code) (county)

Please provide name and phone number of additional contact person to act on your behalf:

Additional Contact Person _____ Phone _____
(please print)

What kind of cancer _____

Doctor/Clinic Office _____

I verify that I currently am living in Grant County Wisconsin and have a cancer diagnosis. I am requesting assistance from the Grant County Cancer Coalition.

_____
(Applicant's signature) (date)

Request for Assistance: Please explain in detail the assistance you are requesting from Grant County Cancer Coalition. Some examples are gas cards, grocery cards, utilities bills, house or rent payment, medical and pharmacy bills: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

For Office Use Only Case No._____

Grant County Cancer Coalition Board Approval Date _____
(*board signature and date*)

_____ _____
(motion to approve) *(second to approve)*

Phone call to applicant to inform of approval (Yes)_____ ***Note***_____

_____

PLEASE COMPLETE AND KEEP A COPY IN PATIENT'S MEDICAL RECORD
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient/Previous Names	Birth Date/Medical Record Number
Street Address	City, State, Zip Code

AUTHORIZES DISCLOSURE TO:

Grant County Cancer Coalition, Inc.
PO Box 105
Lancaster WI 53813

AUTHORIZES DISCLOSURE BY:

Name of Health Care Provider/Doctor

Address

City, State, Zip Code

FAX No.

ATTN:

INFORMATION TO BE DISCLOSED:
Verification of current diagnosis related to cancer or treatment related to cancer. The Coalition requires a verbal verification only; no records need to be sent.

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through Grant County Cancer Coalition, Inc. A member of the GCCC board will be contacting the doctor's office to verify you have cancer.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or receive a copy of the Health Information to be used or disclosed – I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to withdraw this authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for 90 days from the date signed.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____

Date: _____

(If signed by other than patient, state relationship and authority to do so)

Grant County Cancer Coalition, Inc.
PO Box 105
Lancaster WI 53813

DIAGNOSIS VERIFICATION FORM

I am verifying that _____
(patient's name)

has a current diagnosis of cancer and is/will be receiving treatment related to cancer.

_____
Physician's Signature

Date _____

_____
(please print name of physician here)

Address: _____

_____

Phone No. _____