

BECKSTRAND CANCER FOUNDATION

20341 Birch Street, Ste. #310 • Newport Beach, CA 92660
 Ph. 949-955-0099 • Fax 949-955-0070 • www.beckstrand.org

IPA APPLICATION

Thank you for your interest in Beckstrand Cancer Foundation's Individual Patient Assistance (IPA) program. Our organization is centered on the timeless and simple philosophy of "people helping people." Our focus is to provide assistance with day-to-day living, short-term financial aid, advocacy, supportive counseling, community resources and life-planning in order to assist patients who qualify cope with the challenges of cancer and bridge them to the next level of functioning and survival.

To be considered for assistance, you must:

- reside in Orange or Los Angeles County
- have been diagnosed with cancer within the past year or have on-going cancer, which is subject to verification by your doctor
- be a lawful U.S. resident (proof required)
- be currently undergoing aggressive treatment, or have just completed treatment within three weeks

[Please note that long-term hormonal treatments do not qualify as forms of aggressive treatment.]

Submit your completed application to the Beckstrand Cancer Foundation mailing address above. **Incomplete applications, including requested additional information on Page 3, will be returned and delay the review process.** Please allow at least three weeks for the completion of your case.

| PATIENT INFORMATION | | |
|---------------------|------------|----------------|
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| STREET ADDRESS | CITY | ZIP CODE |

| | | | |
|---------------|----------------|-------------------|--------|
| HOME PHONE | CELL PHONE | | |
| WORK PHONE | OTHER | | |
| EMAIL ADDRESS | | | |
| DATE OF BIRTH | PLACE OF BIRTH | SOCIAL SECURITY # | GENDER |

Please provide proof of identification & copy of social security card. **For non native-born applicants**, please provide proof of legal residency (i.e. copy of Permanent Resident Card, U.S.-issued passport).

MARITAL STATUS Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

If married, spouse's name _____

MINOR OR ADULT CHILDREN

| NAME | RELATIONSHIP TO YOU | AGE | GENDER | LIVES W/ YOU? |
|------|---------------------|-----|--------|---------------|
| 1. | | | M / F | Y / N |
| 2. | | | M / F | Y / N |
| 3. | | | M / F | Y / N |
| 4. | | | M / F | Y / N |
| 5. | | | M / F | Y / N |

| MEDICAL INFORMATION | |
|---------------------------|---|
| MEDICAL INSURANCE CARRIER | GROUP NUMBER |
| TELEPHONE NUMBER | PATIENT'S RELATION TO INSURED (circle one) SELF SPOUSE PARENT CHILD |

| | |
|---|-------------------|
| TO BE COMPLETED BY YOUR DOCTOR: CURRENT CANCER DIAGNOSIS & STAGE | DATE OF DIAGNOSIS |
| REOCCURENCE? YES NO | |

| |
|---|
| TO BE COMPLETED BY YOUR DOCTOR: CANCER-RELATED MEDICATIONS CURRENTLY TAKEN |
|---|

| |
|--|
| TO BE COMPLETED BY YOUR DOCTOR: OTHER CANCER-RELATED TREATMENTS |
|--|

| DOCTOR INFORMATION (HIPPA Release) [45 C.F.R. § 164.508 (c)(ii) & Civ. Code § 56.11 (c)] | |
|--|---------------------|
| MEDICAL ONCOLOGIST (CANCER DOCTOR) | DIRECT OFFICE PHONE |
| RADIATION ONCOLOGIST (IF APPLICABLE) | DIRECT OFFICE PHONE |
| MEDICAL ONCOLOGIST'S SIGNATURE | DATE OF SIGNATURE |
| PATIENT'S SIGNATURE (authorizes release of medical information) | DATE OF SIGNATURE |
| Description of the information to be released [45 C.F.R. § 164.508 (c)(i) & Civ. Code § 56.11 (d) & (g)] | |

Telephonic conference and/or faxed documents between Beckstrand Cancer Foundation, the above listed patient and doctor's office regarding patient's medical diagnosis, current treatment and history.

| Description of each purpose for the use or release of the information [45 C.F.R. § 164.508 (c)(iv)] |
|--|
|--|

This information will be used for the sole purpose of evaluating the above patient for support services offered by Beckstrand Cancer Foundation. This HIPPA release is valid for a 180-day period from the patient's signature date shown above and only if signed by both the patient & oncologist's office.

| WORK HISTORY | | |
|--------------------------------|--------------------------|-------------------------------|
| MOST RECENT EMPLOYER | JOB TITLE | HRS. PER WEEK |
| CURRENTLY WORKING? | IF NOT, LAST DAY OF WORK | MONTHLY INCOME (when working) |
| MOST RECENT EMPLOYER OF SPOUSE | JOB TITLE | HRS. PER WEEK |
| CURRENTLY WORKING? | IF NOT, LAST DAY OF WORK | MONTHLY INCOME (when working) |

FULL DISCLOSURE IS NEEDED FOR YOUR APPLICATION TO BE CONSIDERED

Please note that no response to the question of monthly income may be the basis for disqualification.
 If the applicant is a minor or dependent adult, please state the income of the patient's parents or guardian.

| MONTHLY INCOME Asterisks (**)= Proof required where indicated (if applicable). | |
|---|-------|
| 1. CURRENT WAGES / SALARY** | 1. \$ |
| 2. SPOUSE'S WAGES / SALARY** | 2. \$ |
| 3. CHILD SUPPORT BENEFITS** | 3. \$ |
| 4. ALIMONY | 4. \$ |
| 5. ROOMMATE / BOARDER | 5. \$ |
| 6. VETERANS, RETIREMENT, AND/OR PENSION BENEFITS | 6. \$ |

| Have you applied for any of the following? (In the second column, please circle "A" if accepted, "P" if pending or "D" if denied.) | | If accepted, indicate what you are receiving each month. |
|--|-------|--|
| 7. STATE DISABILITY** | A P D | 7. \$ |
| 8. SOCIAL SECURITY DISABILITY (SSD)** | A P D | 8. \$ |
| 9. SUPPLEMENTAL SECURITY INCOME (SSI)** | A P D | 9. \$ |
| 10. SOCIAL SECURITY (OVER 65) | A P D | 10. \$ |
| 11. STATE UNEMPLOYMENT | A P D | 11. \$ |
| 12. IN-HOME SUPPORTIVE SERVICES | A P D | 12. \$ |
| 13. FOOD STAMPS | A P D | 13. \$ |
| 14. AFDC | A P D | 14. \$ |
| 15. OTHER | A P D | 15. \$ |
| TOTAL MONTHLY INCOME (Lines 1 – 15) | | \$ |

BALANCE CURRENTLY IN: Bank Checking Account** \$ _____
 Bank Savings Account** \$ _____
 IRA or 401K \$ _____

| MONTHLY EXPENSES Asterisks (**)= Proof required where indicated (if applicable). | | |
|--|--------|-----------|
| 1. MORTGAGE** or RENT** Circle one; provide proof with a cancelled check or receipt. If renting, list landlord name, phone number & name of apartment complex (if applicable) directly below: | 1. \$ | |
| 2. GAS | 2. \$ | |
| 3. ELECTRIC | 3. \$ | |
| 4. WATER | 4. \$ | |
| 5. PHONE | 5. \$ | |
| 6. FOOD | 6. \$ | |
| 7. AUTO: Monthly payment** (Make _____ Yr. _____) | 7. \$ | |
| 8. AUTO: Monthly gasoline | 8. \$ | |
| 9. AUTO INSURANCE** | 9. \$ | |
| 10. HEALTH INSURANCE PREMIUM** How often paid (if not monthly)? | 10. \$ | |
| 11. MEDICATIONS Cancer-related or other chronic conditions | 11. \$ | |
| 12. CO-PAYMENTS | 12. \$ | |
| 13. MEDICAL EXPENSES NOT COVERED BY INSURANCE | 13. \$ | |
| TOTAL MONTHLY EXPENSES (Lines 1 – 13) | | \$ |

Do you receive monetary support from other sources (friends, family, religious communities)? Please explain:

Please provide emergency contact information for one person the patient has regular contact with:

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Email Address _____

If you are a non-English speaker, please provide the name and phone number of a relative or friend whom we may contact to translate.

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Email Address _____

Who referred you to Beckstrand Cancer Foundation?

Name _____ Phone Number _____

Organization/ Agency & Position _____

Please add any comments or information you would like Beckstrand Cancer Foundation to know:

For administrative purposes, organizations involved with your case may be contacted to verify the information you have provided on this application. With your signature, you acknowledge and agree to the above stipulations.

Signature _____ **Date** _____

Before you submit your application, did you remember to include the following?

- Medical information completed & signed by your oncologist, followed by your signature?
- Proof of monthly income in the form of wages, State Disability, SSD and/or SSI?
- Proof of your monthly bank account statements (checking and/or savings, if applicable).
- Proof of monthly rent or mortgage? **If paying rent, two consecutive months of paid rent must be provided.**
- If renting, did you provide the name & phone number of your landlord?
- Proof of monthly auto payment? (if applicable)
- Proof of monthly auto insurance? (if applicable)
- Proof of monthly health insurance premium? (if applicable)
- Proof of legal residency (i.e. Permanent Resident Card, U.S.-issued passport)

You **MUST** provide proof of all above items (as they apply to you) to complete your case.

EFFECTIVE JANUARY 1, 2009: Incomplete cases will be given a three-week grace period to allow for completion; applications still incomplete at the end of three weeks will be closed, and the applicant must re-apply for assistance consideration.

BECKSTRAND CANCER FOUNDATION

[45 C.F.R. § 164.508(c)(iii) & Civ. Code § 56.11(f)]

Lil Spitzer • Executive Director

Pam Kennedy, MSW, LCSW • Patient Care Director

Sarah Unke • Office Manager