4 Words Foundation, Inc.
Supporting Cancer Awareness Together

ASSISTANCE REQUEST FORM-CONNECTICUT

Assistance is provided for ***cancer screening, associated testing, and medical item costs only***, for individuals with/without insurance or those who cannot afford their deductible/coinsurance related to these tests. Financial information may be requested during the decision making process and if requested must be provided prior to the scheduled test date. We do not provide financial assistance for prescription medications, mortgage/rent, travel, fuel, food, utilities or other household/personal expenses.

Assistance requests may only be submitted for one (1) facility/physician. Ancillary costs charged by outside providers (ie: labs, pathology) are the patient's responsibility.

There is a maximum limit of one request per patient, per 12month period of $400 for the following assistance requests:

- Cancer Screenings (Mammogram screening, Diagnostic Mammogram, Ultrasound, CT Lung Cancer Screenings, other diagnostic imaging)
- Medical Supplies

There is a maximum limit of one request per patient, per 12 month period of $1,500 for the following assistance requests:

- Additional non-surgical cancer testing procedures (biopsy, etc.)
- Genetic testing (for cancer diagnosis only)
- PET scans

Applicants may only request assistance once per year.

All requests will be reviewed on a case-by-case basis for approval. Requested amount is dependent on availability of funds and may not be available each month. Requested amount may be approved as submitted, denied, or adjusted based upon funds available and insurance coverage. Approval of funds will be awarded without regard to race, national origin, gender, sexual orientation and may be suspended at any time due to unavailability of funds. ***Individuals without insurance will be given first priority.***

All information requested must be included or the application will not be considered.

Approved funding will be paid directly to testing facility and applied directly to patient's account. Prescription for screening/testing is required. All patient personal and financial information will be kept confidential. Generic demographic information may be used in reporting outcomes of assistance program.

PLEASE PROVIDE US SUFFICIENT TIME TO REVIEW APPLICATION.

Referring Physician:	
Physician's Phone Number:	
Patient Full Name:	
Patient Address (street, city, state, zip)	
Patient Phone Number:	
Patient Social Security Number:	
Patient Email Address:	
Screening/Testing/Item Required:	
Testing Facility:	
If "other", facility name:	
Appointment Date and Time: (must be scheduled)	
Gender:	
Age Group:	
National Origin:	
Currently Working?	

Annual Household Income:	
Are you covered by group/individual insurance?	
Medicare/Medicaid?	
Insurance Carrier:	
Reason for Request:	
What other local/national organizations have you or will you be reaching out to?	
Amount Requested:	

Patient/Parent Authorization/Acknowledgement: *I authorize 4 Words Foundation, Inc. to obtain and discuss information related to this request with my physician and other care providers/facilities. I certify the above statements are true. I acknowledge that payment is dependent on approval and availability of funds. All information related to this request will be kept strictly confidential and will not be shared with outside persons or agencies. I also understand that 4 Words Foundation, Inc. may request additional documentation (ie: proof of insurance/non-insurance, financial information, other personal information, etc.) in order to make a decision on the approval and distribution of funds requested. If requested to provide additional documentation I understand that I must provide the requested information prior to the scheduled test date or request for financial assistance may be denied.*

GENERAL RELEASE and TERMS OF ACCEPTANCE: *I hereby release, defend, indemnify, and agree to hold harmless 4 Words Foundation, Inc., its officers, directors, agents, sponsors, medical advisors, volunteers, and employees (if any) from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to my participation in the programs or benefits provided by the 4 Words Foundation, Inc.*

For this request for financial assistance, I warrant the truthfulness of the information provided in this application.

Date: _____

_____

Signature of Applicant

_____

Applicant Name Printed

Email completed form to: info@4wordsfoundation.org

or

Mail completed form to:

4 Words Foundation, Inc.
Attention-Assistance Request
3600 Denia Ct.
Cape Coral, FL 33909