CancerCare® Co-Payment Assistance Foundation

PATIENT NAME _____ **SSN**_____

Welcome to the CancerCare® Co-Payment Assistance Foundation, a non-profit organization that has provided thousands of individuals diagnosed with cancer access to medications they need to help improve their quality of life.

The quickest way to enroll with our Foundation is online through our portal or by calling and speaking with a co-payment specialist. However, if you prefer you can complete the enclosed application and return it to the Foundation along with verification of your diagnosis, household income and copies of your insurance card(s). Completed applications can be received via mail or fax. Details of acceptable documentation and submission options are outlined on page two.

If you qualify and if funding is available, we will provide you with co-payment assistance for one year from your approval date. If you have Internet access and an email address, you should include that on your application and we will email you a username and password so that you may freely access your account found at portal.cancercarecopay.org.

To reiterate, you must fill out the enclosed paperwork, sign it and return it to CancerCare® Co-Payment Assistance Foundation along with your income documents and insurance cards in order to be considered for funding.

Please understand that all approvals are based on available funding and are approved on a first-come, first-serve basis. **Receipt of an application does not guarantee funding.**

Please call us toll-free at (866) 552-6729 if you have any questions or need assistance filling out the following enrollment forms.

Sincerely,

CancerCare Co-Payment Assistance Foundation

Required Documentation & Submission Options

Documentation Required

1. ***Pages 3-5 signed and dated*** where applicable along with income verification documentation.
2. ***Page 6 – completed and signed by your treating Physician.***

3. **INCOME VERIFICATION - YOU MUST SUBMIT A SIGNED COPY OF YOUR MOST RECENT US Federal Income Tax Return** (IRS Form 1040, 1040A, 1040EZ)

   *For Individuals who **did not** file an Income Tax Return*, you must submit the following for both you and your spouse if applicable:

   - A copy of your most recent Social Security/Disability Award Letter, Benefit Statement or monthly check
   - A copy of your W2 -or- most recent paycheck
   - A copy of all other income statements that may be applicable to your specific situation (pensions, annuities, taxable interest income/dividends, business income, rental income)
   - A copy of your Unemployment Check or Benefit Notification

4. A copy of the ***front and back*** of the **Patient's Medical and Prescription insurance card(s)**

****** PLEASE NOTE - Be sure to include a summary of your insurance benefits at the bottom of the enrollment form (page 3). We need to know your out-of-pocket costs for the chemotherapy medication(s).**

Submission Options

You can return your complete application the following ways:

ONLINE

- Uploaded through secure Portal: Documents can be uploaded and attached to the patient record via our secure online patient portal at portal.cancercarecopay.org
- **Email to** information@cancercarecopay.org
- **FAX**: (212) 601-9760

REGULAR US MAIL: For your convenience a prepaid envelope has been enclosed. You should allow **at least 10 business days** for your enrollment form to reach us by regular mail before checking on the status of your application.

Date: SSN:	Patient Name:
Birth Date:	Marital Status: ___ Married ___ Single ___ Divorced ___ Other Specify Other:_____
Mailing Address:	E-mail: Daytime Phone Number Phone Type: ___ Cellular ___ Home ___ Work
Alternate Contact Name: Relationship to Patient:	Contact Phone Number:

INCOME INFORMATION

Annual Household Adjusted Gross Income: $	Number of Dependents Claimed on Taxes:

PHYSICIAN INFORMATION

Physician Name:	Physician Phone: (*if known*)
Office Address: (*if known*)	NPI: (*if known*)

DIAGNOSIS INFORMATION

Primary Cancer Diagnosis: ICD-10:	Medication:
Pharmacy:	Pharmacy Address or Phone: (*if known*)

INSURANCE INFORMATION – Is this a Medicare Plan? _____

Major Medical Insurance Name:			
ID#:	Group #	Phone:	
Deductible Amount: $	**Coinsurance Amount: _____%**	**CoPay Amount For Treatment $**	**How Often Do you have Treatment?**

Prescription Coverage Insurance Name:		Phone:	
ID#	**Rx Coinsurance Amount _____%**	**Rx CoPay Amount**	**Out-of-Pocket Max amount before 100% coverage?_____**
Rx Bin:	Rx PCN	Rx Grp:	

******THIS PAGE MUST BE RETURNED******

PATIENT ATTESTATION Please answer questions below	
Yes No	Are you receiving healthcare benefits through Medicare, Medicaid, or any Federal or State funded insurance or assistance program?
Yes No	Do you agree that the Diagnosis listed on the application is your primary cancer diagnosis and the chemotherapy medication prescribed is for the treatment of that diagnosis? (Your diagnosis will also be verified by your treating physician)

Certification and Acknowledgement:

You agree that all of the information you have provided is truthful and accurate to the best of your knowledge. You understand that you are free at any time to switch providers, practitioners, suppliers, or medications within the Cancer*Care*® Co-Payment Assistance Foundation formulary for your diagnosis without affecting your continued eligibility for assistance. Your application for assistance does not guarantee funding will be available. Any financial assistance that you may be eligible for will only be awarded after documentation of your first dispense has been approved by Cancer*Care*® Co-Payment Assistance Foundation. You understand that if you are awarded financial assistance that it will be provided for one year and that you must notify the foundation of any changes to your income that could affect your award; you also understand that you must reapply annually. There is no guarantee that funding will be available in any subsequent year.

The Foundation cannot keep funds reserved for an individual beyond 90 days from the award effective date. Delay or significant lapse in claims submitted can result in termination of your award. If this happens and you still require assistance, your case will be re-evaluated based on funding availability at that time.

Limitation of Liability:

You agree that the Cancer*Care*® Co-Payment Assistance Foundation, Cancer*Care*®, Inc., and our affiliates, contractors, vendors, agents, sponsors, and donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-payment relief, or other value-added benefits or services provided as a part of this program.

Signature of Individual or Individual's Legal representative (Form MUST be completed before signing)

Date

Print name of Individual's Legal Representative (If applicable)

Relationship or Authority to Act

You must be a legal or authorized representative for the applicant in order to sign this authorization on his/her behalf.

******THIS PAGE MUST BE RETURNED******

CancerCare Co-Payment Assistance Foundation

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

Patient Name: _____ ID: _____

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information" or "PHI") as described below in this form (this "Authorization") by Cancer*Care*® Co-Payment Assistance Foundation, a not-for-profit organization, Cancer*Care*® Inc., and their affiliates (collectively referred to as "Cancer*Care*®").

Name of person(s) or organization(s) authorized to use or receive the Protected Health Information:
Cancer*Care*'s affiliates, contractors, vendors, agents, sponsors, and donors

Specific description of Protected Health Information to be used or disclosed:
Demographic information, contact information, diagnosis, date of birth, social security numbers, disease, drug treatment information, and other individually identifiable health information.

The purpose of the disclosure of Protected Health Information is to:
(i) make determinations for financial assistance; (ii) communicate with your provider regarding your patient assistance for payment and therapy management purposes; (iii) fundraise; and (iv) provide and notify you of additional programs and services available through Cancer*Care*®.

Please fill out an event on which this authorization will expire: Upon written request from patient

Please read the following:

1. I understand that my Protected Health Information may be subject to re-disclosure by the authorized recipient of the PHI pursuant to this Authorization and no longer protected by federal or state privacy regulations.
2. I understand and authorize Cancer*Care*® to de-identify, re-identify and attempt to re-identify me and my Protected Health Information.
3. I understand that my Protected Health Information is subject to electronic disclosure.
4. I understand that I may revoke this Authorization at any time by notifying Cancer*Care*®, in writing, but if I do, it will not have an effect on any actions Cancer*Care*® took before it received the revocation of this Authorization.
5. Revocations must be sent to:

Cancer*Care*® Co-Payment Assistance Foundation 275 7th Ave, 22nd Floor, New York, NY 10001
Attention: HIPAA Security Officer RE: Revocation

Section B: The patient or the patient's representative must read the following statements:

- I understand that I may refuse to sign the Authorization, and that my health care treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this form. However, I understand that my enrollment and eligibility to participate in Cancer*Care*® programs and receive co-payment assistance is conditioned upon signing this form. I understand that by not signing this document my financial assistance payment will only be available through the Reimbursement Program.
- I understand that I have the right to receive a copy of this Authorization after I sign it.

Section C: By signing below you agree that you have read and understand the above statements.
(Form MUST be completed before signing.)

_____ _____
Signature of Individual or Individual's Legal Representative | Date

_____ _____
Print name of Individual's Legal Representative: (If applicable) | Relationship or Authority to Act

You must be a legal or authorized representative for the applicant in order to sign this authorization on his/her behalf.

******THIS PAGE MUST BE RETURNED******

CancerCare Co-Payment Assistance Foundation

Dear Doctor,

The Cancer*Care* Co-Payment Assistance Foundation (CCAF) is a nonprofit organization dedicated to helping patients afford their co-payments for chemotherapy and targeted treatment drugs. We provide this assistance to ensure access to care and compliance with prescribed treatments. To be eligible, patients must meet certain financial and medical criteria related to their diagnosis and treatment. The primary diagnosis for the patient must match our fund definition and the medication prescribed must be to treat the primary diagnosis.

Your patient has already enrolled in our program and was approved based on our initial assessment with the patient or his/her advocate. However, as part of our ongoing compliance requirements, the patient's diagnosis must be verified by the treating physician.

As the treating physician, please complete and sign the form below. **Completed forms can be faxed to our office at 212-601-9760, emailed to information@cancercarecopay.org or uploaded to the patient account via our secure *Patients & Pro's portal* at portal.cancercarecopay.org.**

I certify that I am the treating physician for _____ _____
Patient Name **Date of Birth**

The patient's primary cancer diagnosis is _____ _____
Diagnosis **ICD-10**

_____
Date of Diagnosis **Please Specify:** **Metastatic ____** **Non-Metastatic ____**

Disease Subtype as applicable _____

Lung Cancer – Please Specify: **Non-Small Cell Lung _____** **Small Cell Lung _____**

Thyroid Cancer – Please Specify: **Follicular ____** **Hurthle ____** **Papillary____**

I further certify that the above named patient is **currently undergoing active treatment with chemotherapy and/or targeted treatment medications to treat his/her primary cancer** and I will be overseeing the patient's treatment accordingly.

Medication Name	**Treatment Plan**	**Expected Length of Treatment**

Prescribing Physician

First Name _____ Last Name _____

Address _____ _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

NPI # _____ Office Contact _____

Physician's Signature: _____ **Date**_____

Frequently Asked Questions (FAQ's)

- What value on the Federal Income Tax form will you use to determine my income?
  - **Answer**: Cancer*Care*® Co-Payment Assistance Foundation is required to use the income featured as the "Adjusted Gross Income" If you are not sure if you qualify please call and speak with a Specialist.
- What is the purpose of the Authorization for Use or Disclosure of Protected Health Information form?
  - **Answer**: The Authorization for Use or Disclosure of Protected Health Information form allows Cancer*Care*® Co-Payment Assistance Foundation, and its affiliates, permission to (i) make determinations for financial assistance; (ii) communicate with your provider regarding your patient assistance for payment and therapy management purposes; (iii) fundraise; and (iv) provide and notify you of additional programs and services available through Cancer*Care*® Co-Payment Assistance Foundation and its affiliates.
- Why do I have a letter to my doctor?
  - **Answer**: As part of our compliance requirements, your diagnosis must be verified by your treating physician. Please bring the enclosed physician's verification form with you to your next appointment. Further instructions are included on the form.
- When will I know if I am approved?
  - **Answer**: Once an application is received, Cancer*Care*® Co-Payment Assistance Foundation is committed to ensuring all applications are processed within 24 hours of receipt. To check your status, please feel free to call (866) 552-6729. (Please note, if an application is mailed, please allow 5-7 business days for delivery through standard mail)
- When does my grant expire?
  - **Answer**: Cancer*Care*® Co-Payment Assistance Foundation program runs for one year from the date of approval or upon exhaustion of funding.
- Can I access my account online?
  - **Answer**: Yes, you can check the status of your award online through our secure patient portal at https://portal.cancercarecopay.org and click on **Status Check.** You can also create an account using your email address
    - ✓ In the upper right corner of the home page click on ***sign in***
    - ✓ Login by entering your **email address** for your **user name**.
    - ✓ Follow instructions for forgotten password.
    - ✓ You will receive another email with your password.
- Can my grant be ended without my knowledge?
  - **Answer**: ***Yes. You must begin using your grant within 60 days from the date your grant started***. *A delay or lapse in dispense activity can result in the ending of your grant. If this happens and you still require assistance, your case will be re-evaluated based on available funding.*
- Do you cover the entire co-payment or just certain treatments?
  - **Answer**: CCAF has funding to cover co-payment, coinsurance and deductibles for the Cancer*Care* covered medications only. Any charges for scans, radiation, lab work or symptom management medicines **are not covered**.