Updated 24 Jan 2017

*C*ircle of *C*ancer *C*are (CoCC) ™
Cancer Related Prescription Drug Assistance Request

Eligibility Requirements:

- Women diagnosed with cancer
- Verifiable income 200% or above federal poverty guidelines (see chart below)
- Prescription Drug Payment/Co-payment assistance applies *only* to cancer-related prescription drugs or result of treatment. Copy of prescription and cost must be provided along with pharmacy information to issue payment to. Point of contact information (name & phone number)
- Must be a resident of an area listed below:
    - Cibolo: 78108
    - Schertz/Cibolo/Selma: 78154
    - Universal City: 78148 & 78150
    - Live Oak: 78148, 78154, 78233
    - Converse: 78109
    - New Braunfels: 78130, 78132, 78133, 78135
    - Windcrest: 78239 & 78218
    - Garden Ridge: 78266
    - Seguin: 78155, 78156
    - Marion: 78124
- Approved applicants receive a maximum $1000 prescription assistance for the calendar year
- Payments are mailed to client, but will be made out to pharmacy/*i*ssued to the pharmacy. Reimbursements directly to client are on case by case basis.
- Applicants must re-apply on an annual basis to ensure eligibility requirements are met

Documentation Required with Application:

- ✓ Submit copy of prescription
- ✓ Submit copy of invoice for prescription from pharmacy
- ✓ Submit utility bill; address must be displayed to verify zip code
- ✓ Submit income documentation/pay-stubs/SSI award letter/unemployment

Note: Co-payment assistance is contingent on availability of funds. Allow 10 business days for processing application once complete application is received and verified by CoCC

Patient Name:_____

Address:_____

Phone Number:_____

E-mail:_____

Emergency Contact:_____

Type of Cancer Diagnosis:_____

Date of Diagnosis:_____

Name of prescription drug:_____

How long do you expect to have to take prescription:_____

What is the monthly cost:_____

Are you applying for cost of medication or co-payment:_____

Pharmacy:_____
Address:_____
Phone number:_____
Point of Contact for Billing:_____
Medical Provider Tax Payer ID_____
Account Number:_____

Amount Requesting: $_____

Number of persons in household (including self):_____
Household monthly income:

Income	Self	Spouse
Wages		
Self-employment		
Public assistance		
Social Security		
Unemployment Comp.		
Workmen's Comp.		
Alimony		

Privacy Statement: Personal Identifiable and Health Care Information will be treated and protected as privileged and confidential health information, which is protected by state and federal statues, rules and regulations and will not be shared outside of the organization and medical treatment facility. Any further disclosure of information is prohibited without the specific prior written consent of the person to whom the information pertains, or as otherwise permitted by law.
Circle of Cancer Care (CoCC) is a non-profit organization created to serve female cancer patients living in Schertz, Cibolo, and NE San Antonio of any race, color, nationality, religion, sexual orientation, or ethnic origin. CoCC does not discriminate on the basis of race, color, nationality, religion, sexual orientation or ethnic origin, but client must meet defined eligibility requirements for financial assistance, transportation, and other services offered by CoCC.

Child Support		
Military Entitlements		
Retirement Pay/Pensions		
Other income (rent/dividends)		
TOTAL		

Federal Poverty Level 2017: To be eligible to apply for co-payment assistance family income cannot exceed 200% above federal poverty level.

Persons in Household	**Federal Poverty guideline**	**200% below poverty level**
1	$11,880	$23,760
2	$16,020	$32,040
3	$20,160	$40,320
4	$24,300	$48,600
5	$28,440	$56,880
6	$32,580	$65,160
7	$36,730	$73,460

Patient Authorization to use or release Protected Health Information

I authorize the use and disclosure of my individual identifiable health information ("Protected Health Information") to Circle of Cancer Care (CoCC), a non-profit Texas organization, to process my application for the "Prescription Financial Assistance Program," if I am eligible and there are funds available.

I authorize the following physician/medical institution to release information:

_____

_____

I authorize my health care provider to disclose to CoCC my health information verbally or written to be used for the purposes stated above. I understand that my Protected Health Information may be subject to re-disclosure pursuant to this authorization. I may withdraw this authorization by mailing or e-mailing a letter of revocation to CoCC, but if I do, it will not have an effect on any actions CoCC took before it received revocation of this authorization. If I revoke this authorization, I will no longer be eligible to receive assistance from CoCC through this program.

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This authorization expires on:_____

Printed Name of Patient:_____

Date of Birth:_____

Social Security Number:_____

By signing this document, I agree that all the information provided is truthful and accurate to the best of my knowledge. I understand that the application for assistance does not guarantee funding will be available. I understand that if I am awarded financial assistance that I must re-apply every calendar year and provide updated income information each calendar year. There is no guarantee that funding will be available in and subsequent year.

Signature of Patient:_____Date:_____

Mail completed application to Circle of Cancer Care, PO Box 303, Cibolo, Texas 78108
Or scan and email to: info@circleofcancercare.org

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