Circle of Cancer Care (CoCC) ™
Cancer Treatment & Prescription Drug Co-Payment Assistance Request Form

Eligibility Requirements:

- Women diagnosed with cancer
- Verifiable income 200% or above federal poverty guidelines (see chart below)
- Co-payment assistance applies *only* to cancer-related medical facilities and cancer related prescription drugs
- Documentation from the medical facility/pharmacy must be provided along with account name, 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 co-payment assistance for the calendar year
- Co-payments are issued directly to the medical treatment facility *only.* *Reimbursement directly to client are evaluated on case-by-case basis.*
- Applicants must re-apply on an annual basis to ensure eligibility requirements are met

Documentation Required with Application:

- ✓ Submit invoice or bill from medical treatment with co-payment amount
- ✓ Submit utility bill; address must be displayed to verify zip code
- ✓ Submit income documentation/pay-stubs
- ✓ Incomplete applications without supporting documents will not be processed

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:_____

Option 1: Treatment Needed: Please circle or highlight each applicable (up to $1000 each calendar year)

Chemotherapy Start Date_____ Stop Date_____
Radiation Start Date_____Stop Date_____
Surgery Date:_____

Physician/Treatment Facility:_____
Address:_____
Phone number:_____
Point of Contact for Billing:_____
Medical Provider Tax Payer ID_____
Account Number:_____

Amount Requesting: $_____

Option 2: For cancer related prescription drug co-payment (up to $1000 per calendar year)

Name of prescription
drug(s):_____
_____
Monthly cost/submit invoice:
How long to you anticipate you will have to take the medications:_____
Name of physician or pharmacy you use:_____
Account number or client ID:_____
Address_____
Phone number:_____
Account number or reference number:_____
Billing contact person:_____

Amount Requesting: $_____

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

Income	Self	Spouse
Wages		
Self-employment		
Public assistance		
Social Security		
Unemployment Comp.		
Workmen's Comp.		
Alimony		
Child Support		
Military Entitlements		
Retirement Pay/Pensions		
Other income (rent/dividends)		
TOTAL		

Federal Poverty Level 2021: 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% above poverty level
1	$12,760	$25,520
2	$17,240	$34,480
3	$21,720	$43,440
4	$26,200	$52,400
5	$30,680	$61,360
6	$35,160	$70,320
7	$39,640	$79,280

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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 "Co-payment Assistance Program," if I am eligible and there are funds available and to administer the Co-payment assistance program.

I authorize the following physician/medical institution to release information, fill in your oncologist/surgeon/pharmacy name below:

_____

_____

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.

This authorization expires on:_____

Printed Name of Patient:_____

Date of Birth:_____

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:_____

Scan/e-mail completed application with supporting documents to:
info@circleofcancercare.org
or mail completed application to

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.

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Updated January 2021

Circle of Cancer Care, PO Box 303, Cibolo, Texas 78108

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