Directions for Completing Packet

1) **Application Form**

   All areas must be completed (except those marked JCOCC Rep)
   Please give as much information as possible

2) **Authorization for Disclosure of Health Information**

   This form must be filled out by the applicant before seeing your doctor.
   He/ She must see this form to verify your diagnosis.

3) **Diagnosis Verification Form**

   This form must be completed by your doctor

4) All three forms listed above must be returned to the JCOCC board to have your request acted upon.

5) **Also please attach a copy of a phone bill, electric bill, mortgage/rent payment, water/sewer bill to verify your residence in Jefferson County.**

Our mission is to assist cancer patients in the Jefferson County Area. As applications are submitted, each will be given a case number, allowing as much confidentiality as possible, with only one board member knowing the applicant's name. We are dedicated to being fair to everyone and it is our hope to be able to meet the needs of everyone that apply.

Please fill out all areas of the forms where needed.

Client # _____

ATTN: Application Committee
Jefferson County Cancer Coalition
PO Box 448
Fort Atkinson, WI 53538

Name _____ Phone (____) _____

Address _____ County _____

City _____ Zip Code _____

Married____ Single____ Children Yes No Ages _____

Oncologist/Doctor _____ Phone (____) _____

Diagnosis _____ Birth Date _____

Please provide name and phone number of additional contact to act on your behalf:

Additional Contact Person _____ Phone (____) _____

I verify that I currently am living **FULL TIME** in Jefferson County Wisconsin **(JCOCC must have a copy of one of the following; phone bill, electric bill, water/sewer bill, mortgage/rent payment to verify residency attached to this application)** and have a cancer diagnosis that I am currently being treated for. I am requesting assistance from Jefferson County Cancer Coalition

_____

_____ (Applicant's signature)

.....

Please place a checkmark where assistance is needed:

____ Utility Bills, Utility Company _____

____ Groceries, Name of grocery store _____

____ Medicine, Name of pharmacy _____

____ Gas Vouchers, Preferred gas station _____

____ Medical Costs, Hospital/Clinic _____

____ Rent/Mortgage, Please include a copy of the Rent or Mortgage statement

How did you hear about Jefferson County Cancer Coalition? _____

Is this the first time you have applied for assistance from JCOCC _____

Request for Assistance: Please explain in detail what you are asking Jefferson County Cancer Coalition to help with. Include details of what assistance you are currently receiving: _____

_____

_____

_____

_____

_____

Please be very specific about why you need the financial assistance and what sort of help you are looking for. Please provide additional pages if needed to make your request for assistance.

For JCOCC Use Only

Jefferson County Cancer Coalition Board Approval/Denial Date _____
(board signature and date)

Date of client contact _____ Time _____ Left message _____

Date of client contact _____ Time _____ Left message _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient/Previous Names	Birth Date/Medical Record Number
Street Address	City, State, Zip Code

AUTHORIZES DISCLOSURE TO:

Jefferson County Cancer Coalition, Inc.
PO Box 448
Fort Atkinson, WI 53538

AUTHORIZES DISCLOSURE BY:

Name of Health Care Provider
Street Address_____
City, State, Zip Code_____
Fax #_____
Attn:_____

INFORMATION TO BE DISCLOSED:
Verification of current diagnosis related to cancer or treatment related to cancer.

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through Jefferson County Cancer Coalition, Inc.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or receive a copy of the Health Information to be used or disclosed – I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. The consequence of not signing the authorization form would be information will not be disclosed. Right to withdraw this authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good for 90 days from the date signed.
I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____
Date: _____
(If signed by other than patient, state relationship and authority to do so)

PO Box 448
Fort Atkinson, Wi 53538

DIAGNOSIS VERIFICATION FORM

I am verifying that _____
(patient's name)

has a current diagnosis of cancer and is currently under my care.

_____
Physician's Signature

Date _____

_____
(please print name of physician here)

Address: _____

_____

Phone No. _____

Fax No. _____

Attention_____