



444 West Ocean Blvd., Suite 800
Long Beach, CA 90802

A Program of Pacific Shores Hematology Oncology Foundation
800-303-0131
www.pacificshoresfoundation.org

REFERRING PHYSICIAN AND PATIENT GRANT REQUEST APPLICATION 2010

Thank you for your interest in applying for a grant from the Woman to Woman Campaign,

A program of Pacific Shores Hematology - Oncology Foundation.

The Woman to Woman Campaign seeks to alleviate the added stress that economically disadvantaged women must deal with when facing the need for drugs and treatments that are beyond their means. The campaign's goal is to provide these women some relief from financial worry and access to life-saving treatments, tests, drugs, and other expenses directly related to access to treatment/research as well as help with the implementation of the therapy plan. Most grants range from \$250.00 - \$2,500.00

To be considered for assistance,

- Must have a verified financial need
- Treatment, drug or medical support must be deemed necessary by the treating physician, and the intervention must have a reasonably favorable probability of benefitting the patient.
- Be a woman over the age of 18, diagnosed with cancer and in a medically supervised treatment plan
- Be referred by a physician or through a medically supervised patient support group or other qualified organization
- Be a resident of Los Angeles or Orange Counties and be a lawful U.S. Citizen
- Payments must be made to the service provider only.

NOTE: Incomplete applications will be returned and will delay the review process.

All decisions regarding grant recipients are reviewed and approved by the Woman to Woman Campaign's grant committee. Those requests for investigational treatment will be referred to a review panel of expert oncologists before a final decision is made.

Submit the completed application to the Pacific Shores Hematology - Oncology Foundation at the following address:

444 West Ocean Blvd., Suite 800, Long Beach, CA 90802

PATIENT INFORMATION- *Completed by patient, family member or guardian or physician/facility*

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS	CITY	ZIP CODE

HOME PHONE	CELL PHONE		
WORK PHONE	OTHER		
EMAIL ADDRESS			
DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY #	GENDER

Please provide proof of identification & copy of social security card. For non native-born applicants, please provide proof of legal residency (i.e. copy of Permanent Resident Card, U.S.-issued passport).

MEDICAL INFORMATION- *Completed by physician or facility medical team only*

MEDICAL INSURANCE CARRIER	GROUP NUMBER
TELEPHONE NUMBER	PATIENT'S RELATION TO INSURED <i>(circle one)</i> SELF SPOUSE PARENT CHILD

CURRENT CANCER DIAGNOSIS & STAGE	DATE OF DIAGNOSIS
CANCER-RELATED MEDICATIONS CURRENTLY TAKEN	
OTHER CANCER-RELATED TREATMENTS OR CLINICAL RESEARCH	

PLEASE DESCRIBE IN DETAIL THE SPECIFIC SUPPORT REQUESTED TIMELINE (months) AND *ESTIMATED COST (refer to eligibility criteria page 1) (treatment, diagnostic and maintenance testing, drugs, and access)

FINANCIAL SUPPORT WILL BE GRANTED FOR ONLY WHAT IS SPECIFIED BELOW (please print clearly)

GRANTS TYPICALLY RANGE FROM \$250.00 – \$2,500.00

* refer to physician's statement document attached

DOCTOR INFORMATION (HIPPA Release) [45 C.F.R. § 164.508 (c)(ii) & Civ. Code § 56.11 (c)]

MEDICAL ONCOLOGIST (CANCER DOCTOR)	DIRECT OFFICE PHONE
RADIATION ONCOLOGIST (IF APPLICABLE)	DIRECT OFFICE PHONE
MEDICAL ONCOLOGIST'S SIGNATURE	DATE OF SIGNATURE
PATIENT'S SIGNATURE (authorizes release of medical information)	DATE OF SIGNATURE

Description of the information to be released

[45 C.F.R. § 164.508 (c)(i) & Civ. Code § 56.11 (d) & (g)]

Teleconference and/or faxed documents between Pacific Shores Hematology Oncology Foundation, the above listed patient and doctor's office regarding patient's medical diagnosis, current treatment and history.

Description of each purpose for the use or release of the information

[45 C.F.R. § 164.508 (c)(iv)]

This information will be used for the sole purpose of evaluating the above patient for medical support services offered by Pacific Shores Hematology Oncology Foundation's Woman to Woman Campaign Program. This HIPPA release is valid for a 180-day

period from the patient's signature date shown above and only if signed by both the patient & oncologist's office

Section to be completed by patient or family member/guardian

WORK HISTORY

MOST RECENT EMPLOYER		JOB TITLE	HRS. PER WEEK
CURRENTLY WORKING?	IF NOT, LAST DAY OF WORK		MONTHLY INCOME (when working)

MOST RECENT EMPLOYER OF SPOUSE		JOB TITLE	HRS. PER WEEK
CURRENTLY WORKING?	IF NOT, LAST DAY OF WORK		MONTHLY INCOME (when working)

MARITAL STATUS Single ___ Married ___ Separated ___ Divorced ___
 ___ Widowed ___

If married, spouse's name _____

MINOR OR ADULT CHILDREN

NAME	RELATIONSHIP TO YOU	AGE	GENDER	LIVES W/ YOU?
1.			M / F	Y / N
2.			M / F	Y / N
3.			M / F	Y / N
4.			M / F	Y / N
5.			M / F	Y / N

FULL DISCLOSURE IS NEEDED FOR YOUR APPLICATION TO BE CONSIDERED

Please note that no response to the question of monthly income may be the basis for disqualification.
 If the applicant is a dependent adult, please state the income of the patient's guardian.

MONTHLY INCOME ** Please provide proof where indicated (if applicable).

1. CURRENT WAGES / SALARY**	1. \$
2. SPOUSE'S WAGES / SALARY**	2. \$
3. CHILD SUPPORT BENEFITS	3. \$
4. ALIMONY	4. \$
5. ROOMMATE / BOARDER	5. \$

6. VETERANS, RETIREMENT, AND/OR PENSION BENEFITS	6. \$
--	-------

Have you applied for any of the following? (In the second column, please circle "A" if accepted, "P" if pending or "D" if denied.)		If accepted, indicate what you are receiving each month.
7. STATE DISABILITY**	A P D	7. \$
8. SOCIAL SECURITY DISABILITY (SSD)**	A P D	8. \$
9. SUPPLEMENTAL SECURITY INCOME (SSI)**	A P D	9. \$
10. SOCIAL SECURITY (OVER 65)	A P D	10. \$
11. STATE UNEMPLOYMENT	A P D	11. \$
12. IN-HOME SUPPORTIVE SERVICES	A P D	12. \$
13. FOOD STAMPS	A P D	13. \$
14. AFDC	A P D	14. \$
15. OTHER	A P D	15. \$
TOTAL MONTHLY INCOME (Lines 1 - 15)		\$

BALANCE CURRENTLY IN: Bank Checking Account \$ _____

Bank Savings Account \$ _____

IRA or 401K \$ _____

MONTHLY EXPENSES **Please provide proof where indicated (if applicable).

1. MORTGAGE** or RENT** Circle one; provide proof with a cancelled check or receipt.	1. \$
If renting, list landlord name, phone number & name of apartment complex (if applicable) directly below:	
2. GAS	2. \$
3. ELECTRIC	3. \$
4. WATER	4. \$
5. PHONE	5. \$
6. FOOD	6. \$
7. AUTO: Monthly payment** (Make _____ Yr.	7. \$

_____)	
8. AUTO: Monthly gasoline	8. \$
9. AUTO INSURANCE	9. \$
10. HEALTH INSURANCE PREMIUM** How often paid (if not monthly)?	10. \$
11. MEDICATIONS Cancer-related or other chronic conditions	11. \$
12. CO-PAYMENTS	12. \$
13. MEDICAL EXPENSES NOT COVERED BY INSURANCE	13. \$
14. OTHER MONTHLY MEDICAL EXPENSES	14. \$
15. OTHER MONTHLY EXPENSES (GENERAL)	15. \$
TOTAL MONTHLY EXPENSES (Lines 1 - 15)	\$

Do you receive monetary support from other sources (friends, family, religious communities)? Please explain:

If you are a non-English speaker, please provide the name and phone number of a relative or friend whom we may contact to translate.

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Email Address _____

Please add any comments or information you would like the grant committee at Pacific Shores Hematology - Oncology Foundation to know that relates to your request for support:

For administrative purposes, organizations involved with your case may be contacted to verify the information you have provided on this application. With your signature, you acknowledge and agree to the above stipulations.

Signature _____ Date _____

Pacific Shores Hematology - Oncology Foundation
 Woman to Woman Campaign Program
 [45 C.F.R. § 164.508(c)(iii) & Civ. Code § 56.11(A)]

Please return the completed form signed by the referring physician and the patient to:

444 West Ocean Blvd., Suite 800
Long Beach, CA, 90802
Attention: Jann Buaiz, MS, Program Director