FUNDRAISING ELIGIBILITY FORM

What is your age?_____What is your family's yearly income before taxes?_____Number of people in household?_____

Last Name:_____First Name:_____Middle Initial:_____Other last names used:_____

Mailing Address:_____City:_____State:_____Zip:_____County:_____

Birth Date:_____ Social Security Number:_____

Email:_____ Home Phone_____Cell phone_____
Messages ok at these numbers? ___YES ___NO

Are you Hispanic? ___ YES ___NO ___Unknown

What race best describes you? __White __ American Indian/Alaska Native ___ Black/African American ___ Asian___ Native Hawaiian/Pacific Islander ___Other/unknown

Healthcare Coverage Do you have Medicare Part B? ___ YES___ NO Do you have Medicaid? ___YES ___ NO Do you have health insurance? ___ YES __ NO
Name: How much is the deductible?
Have you been referred to the Marketplace for health insurance or Expanded Medicaid Plans? ___YES ___NO Referral Date

Medical Background: What are your financial needs? Who & where is your medical service provider?
Screening date: Diagnosis date: Diagnosis: Treatment plan:
Use Cessation MT QUIT Line: 1-800-QUIT-NOW Do you use tobacco? ___ YES ___ NO ___ I am ready to quit & ask that a quit line coach call me, I understand that the MT Quit Line will inform my provider about my participation Please sign the Montana Tobacco Quit Line Patient Fax Referral Form Authorization to Release Information section on the Informed Consent and Authorization to Disclose Health Care Information page. ___ I do not want a Quit Line coach to call me

How did you hear about the program? ___ Medical Provider Name:_____ Internet _____ TV _____Re-screen/Previously enrolled _____Family/Friend/Word of Mouth _____Presentation_____MAIWHC _____Fair - Job/Health or Pow Wow _____Special Promotion/Promo Ad _____Newspapers/Newsletters _____Government Office _____Radio _____Other:

What health areas would like assistance with?

Are there any circumstances that might prevent you from receiving your cancer treatment or screening services? Please describe those circumstances below, if none, check None _____ Lack of transportation _____Time off of work _____None _____Other, please describe:

Do you need assistance with any of the following to access medical services? Check all that apply _____ Difficulty with hearing _____Difficulty with vision _____Difficulty dressing or bathing _____Difficulty with concentration, remembering or making decisions _____Difficulty with mobility, such as walking or climbing stairs _____Difficulty doing errands such as visiting a doctor's office or shopping _____None

What resources are you or your family interested in learning more about from the following topics? _____ Arthritis Exercise Programs _____Self _____Family _____Diabetes _____Self _____Family_____Asthma _____Self _____Family _____Injury Prevention _____Self _____ Family _____Cardiovascular Health _____Self _____Family _____Nutrition and Physical Activity _____Self _____Family _____Chronic Disease Self-Management Program: Living Life Well _____Self _____Family _____None, not interested _____Self _____Family

Please Read and Sign the Informed Consent and Authorization to Disclose Health Care Information on the next page

FUNDRAISING ELIGIBILITY FORM

Please Read and Sign Informed Consent and Authorization to Disclose Health Care Information

Central Montana Family Planning/ Montana Cancer Screening Program (CMFP/MCSP) receives private donations from fundraising events to provide financial assistance for cancer screening, diagnostic services and treatments for those that do not qualify for the CDC funded program through our office called Montana Cancer Screening Program (MCSP). Fundraising eligibility is based on those individuals who fall outside of our CDC age and income and screening guidelines for non- eligible Montana residents. CMFP/MCSP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment via charity care applications with providers and facilities and or public assistance application. By enrolling in the CMFP/MCSP fundraising program you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

If I need other services that are not covered, the CMFP staff will refer me to agencies that may help provide financial assistance for my treatment. I understand that I may be billed for services not covered by some fundraising assistance and those costs are mine. CMFP/MCSP will offer partial funds to assist me with medical provider and facility expenses, radiology, pathology, travel to and from treatment via fuel cards and or motel costs, and limited pharmacy as well as cancer treatment costs. Individual financial assistance will be considered depending on income status.

I understand I have not met the eligibility guidelines for the Montana Cancer Control Program (MCCP) which is CDC funded. I may have insurance coverage and still be eligible to participate in this fundraising program. However, my insurance will be billed first for my cancer services. If the services are not fully reimbursed by my insurance, the CMFP/MCSP can offer some fundraising assistance with the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider and those I am seeking financial assistance with, and to the CMFP/MCSP staff. The CMFP/MCSP staff means those personnel and those individuals who will see my medical and other claim costs via the payment processes. You will have a chart kept on file at the CMFP/MCSP office in which your billing information will be kept. Medical information regarding me will be kept to a minimum. The amount of information will be only necessary to function for the expenses I am seeking financial assistance for.

I consent to and authorize the mutual exchange of screening and diagnostic/ treatment records/ billing among the CMFP/MCSP staff, my health care provider(s), the laboratory/pathologist/ oncologist, and any radiology facility or other related service business received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the CMFP/MCSP and agree to participate in the program. I have had an opportunity to ask questions about the CMFP/MCSP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the CMFP/MCSP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the CMFP/MCSP fundraising assistance at any time.

Montana Tobacco QUIT Line - Patient Fax Referral Form Authorization To Release Information Yes, I am ready to quit & ask that a quit line coach call me. I understand that the Montana Tobacco Quit Line will inform my provider about my participation. Client Signature:

Client Signature:	Print Full Name:
Date:	