

**CANCER ASSOCIATION**  
824 Elmwood Park Boulevard, Room 240  
New Orleans, Louisiana 70123-3342

**FAX Line:** (504) 733-0252  
(SEND IN THIS FORM **NOW**)

**TELEPHONE:** 529-2273, 733-5539, **WITHIN** Metro New Orleans

**TOLL FREE:** 1-800-624-2039, **OUTSIDE** Metro New Orleans

**PRINT OR TYPE LEGIBLY**

CLINIC NUMBER: \_\_\_\_\_

**PATIENT SERVICES ELIGIBILITY FORM**

FOR THE PERIOD OF  
**July 1, 2011 through June 30, 2012**

Patient's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_

Apartment \_\_\_\_\_

City \_\_\_\_\_, LOUISIANA Zip \_\_\_\_\_ Parish \_\_\_\_\_

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

Email address, if applicable \_\_\_\_\_

Insurance Company \_\_\_\_\_

Does Your Insurance Company Pay for Outpatient Medications(s)?

Yes \_\_\_\_\_

No \_\_\_\_\_

If Yes, What Percentage Does the Insurance Company Pay?

\_\_\_\_\_ percent is paid by the company.

Policy Number \_\_\_\_\_

Effective Date \_\_\_\_\_

Medicare A # \_\_\_\_\_

Effective Date \_\_\_\_\_

Medicare B # \_\_\_\_\_

Effective Date \_\_\_\_\_

Medicare D # \_\_\_\_\_

Effective Date \_\_\_\_\_

Medicaid Number \_\_\_\_\_

Effective Date \_\_\_\_\_

**INCOME:** Please list Family member's name, **ALL SOURCES** of income **AND** include **AMOUNTS OF EACH SOURCE OF INCOME.**

	Family Member's Name	Amount of Income	Source of Income and/or Place of Employment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

**FAMILY INFORMATION:** Please list **ALL** family members who are **LIVING WITH THE PATIENT** and include any information about any health problems of

those family members, their relationship to the patient, and ages of family member(s).

Family Member's Name, age, relationship to patient	Health Problem, if any
1. _____ _____	
2. _____ _____	
3. _____ _____	
4. _____ _____	
5. _____ _____	
6. _____ _____	

**STATISTICAL INFORMATION:** (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE \_\_\_\_\_ SEX \_\_\_\_\_ NATIONALITY \_\_\_\_\_

**INFORMATION ABOUT THE PATIENT'S ILLNESS:** PLEASE PRINT!

1. PHYSICIAN'S NAME \_\_\_\_\_

EMAIL \_\_\_\_\_

SECTION/DEPARTMENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

DEPARTMENT'S TELEPHONE NUMBER(S) \_\_\_\_\_

DEPARTMENT'S FAX NUMBER(S) \_\_\_\_\_

2. DIAGNOSIS: **CANCER OF** \_\_\_\_\_

Stage	1	2	3	4	Metastasis to
_____					

3. PLACE OF TREATMENT \_\_\_\_\_

4. LIST OF MEDICATION(S) **LIST BOTH THE QUANTITY(IES) OF THE PRESCRIPTION(S) DISPENSED (the number of pills the patient will need) AND THE DOSAGE(S) OF THE MEDICATION(S) DISPENSED in a 30-day supply:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. If you are requesting assistance with utility bills (water, gas, electricity), medical bills, etc., please include a copy of those bills **WITH** this application; if you are requesting assistance with your rent, you must include a copy of your lease, which also states the amount of your rent and the name and address to which to submit payment. If you are requesting assistance with your mortgage, you must include a copy of your premium notice. This must have the amount of the note, your name and address, the account number, and the name and address of the company to which to submit payment.

6. If you are requesting assistance with transportation **FOR MEDICAL APPOINTMENTS ONLY** (assistance provided in the form of a gas card - \$25 for every 100 miles), please send **FROM THE PHYSICIAN**, a list of your appointments and the name and addresses of your appointments and the name and address of the physician and/or medical facility. We must also have the patient's physical address.

7. **BREAST CANCER PATIENTS ONLY:** Please submit copies of all medical bills related to the breast cancer treatment for which assistance is being requested.

8. COLOSTOMY SIZE RECOMMENDED BY YOUR PHYSICIAN \_\_\_\_\_

9. BED/BLUE PADS USED? \_\_\_\_\_ Yes \_\_\_\_\_ No **50 per month provided by Cancer Association**  
Size \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL

NAME OF PERSON SUPPLYING INFORMATION \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE\*\*** of Physician

\_\_\_\_\_  
Physician's Telephone Number and Extension

\*\*By signing this form, I understand that the Cancer Association can provide only the generic equivalents (unless no generic equivalent is available from any of the pharmaceutical companies) and I hereby authorize the use of generic equivalents to be substituted for medications that are prescribed for the above-named patient and paid for by the Cancer Association

\_\_\_\_\_  
**SIGNATURE** of Referring Professional & Title

\_\_\_\_\_  
Referring Professional's Telephone Number and Extension

\_\_\_\_\_  
**PRINTED NAME** of Referring Professional

\_\_\_\_\_  
Referring Professional's Beeper Number

\_\_\_\_\_  
Referring Professional's Email Address

\_\_\_\_\_  
Referring Professional's FAX Number(s)

\_\_\_\_\_  
**PRINTED** Name of Patient

\_\_\_\_\_  
**SIGNATURE** of Patient

\_\_\_\_\_  
Today's Date (**PLEASE PRINT!!!**)

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**A UNITED WAY AGENCY**

**Use this form ONLY IF:**  
**patient requires the listed medication(s) of:**  
**Phenytoin**  
**Insulin for Injection**  
**Syringes for Insulin Injection**  
**and/or Disposable needles # 21 or # 23.**

Date : \_\_\_\_\_

To : Patricia Entrekin  
Patient Services Coordinator

RE : Statement of Need of Medication as a Result of the Diagnosis of Cancer

Per the requirements of the Cancer Association, a United Way agency, this letter represents that the condition for which assistance with the medications and/or equipment listed below is requested **IS AS A RESULT OF CANCER.** The patient's name is \_\_\_\_\_ The patient suffers from \_\_\_\_\_, **WHICH IS A RESULT OF THE** \_\_\_\_\_ **CANCER.**

Please provide assistance for the following **CIRCLED** medications (strength and quantity to be dispensed in a 30-day supply, as well as directions

on how the medication is to be taken) and/or equipment:

<u>GENERIC/CHEMICAL NAME</u>	<u>BRAND NAME</u>	<u>STRENGTH</u>	<u>QUANTITY</u>	<u>HOW TAKEN</u>
Phenytoin	Dilantin	_____	_____	_____
Insulin for Injection (Diabetes)	_____	_____	_____	_____
Syringes for Insulin Injection	_____	_____	_____	_____
Disposable needles, # 21 or # 23	_____	_____	_____	_____

If you need or require any additional information, please do not hesitate to call \_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_.

Sincerely, \_\_\_\_\_

Signature of Physician **PRINTED** Name of Physician

Physician's Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Telephone (\_\_\_\_\_) \_\_\_\_\_

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**ORAL SUPPLEMENT PRESCRIPTION FORM**

Patient's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_, **LOUISIANA** Zip \_\_\_\_\_ Parish \_\_\_\_\_

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

Delivery Address, if different from above: \_\_\_\_\_

Apartment \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Medicare # \_\_\_\_\_ Effective Date \_\_\_\_\_

Medicaid Number \_\_\_\_\_ Effective Date \_\_\_\_\_

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Nutritional Supplement(s) Ordered:	Frequency	Flavor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

