LIGHT of SW Florida, Inc.
20272 Leopard Lane
Estero, FL 33928

PATIENT ASSISTANCE APPLICATION FORM

Date: ____________________________

PATIENT DEMOGRAPHICS

Name:	Social Security Number:	US Citizen (Circle): Yes No
Address:		County:
City, State, Zip Code:		
Date of Birth:	Phone:	
Employer:	Work Phone:	
Address:		
City, State, Zip Code:		

SPOUSE INFORMATION

Name:	Social Security Number:	US Citizen (Circle): Yes No
Address:		County:
City, State, Zip Code:		
Date of Birth:	Phone:	
Employer:	Work Phone:	
Address:		
City, State, Zip Code:		

DEPENDENT INFORMATION

List Names and Ages of all dependents living at home:

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HOUSEHOLD INFORMATION

Residence: Own_____ Rent_____ If Owner: Value of Residence: $		Est. Equity: $
Monthly Payments or Rent: $	Estimate of Monthly Utilities: $	Taxes/Ins: $

Please list all other monthly obligations with brief explanation of debt: (Please include cost of food, medications, medical bills, anything that will give us a true picture of your needs and obligations)

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FINANCIAL INFORMATION

List Banks & Account information:	
Check Account Balance: $	Savings Account Balance: $
Patient's Monthly Income: $	Please include all sources of income: Social Security, Investment, Wages
Spouse's Monthly Income: $	Unemployment, Child Support, Disability Insurance, etc.
Total Monthly Income from all sources: $	Total Monthly Expenses: $

HEALTH INFORMATION

Cancer Diagnosis:	Date of Diagnosis:
Current Treating Physicians:	
Name:	
Address:	Phone:
City, State, Zip Code:	
Name:	
Address:	Phone:
City, State, Zip Code:	
Name:	
Address:	Phone:
City, State, Zip Code:	
Name:	
Address:	Phone:
City, State, Zip Code:	
Type of treatment you have received or anticipate receiving:	
______________________________	
______________________________	
______________________________	

INSURANCE INFORMATION

Insurance Co.:		Primary Insured:
Address:		Phone:
City, State, Zip Code:		
ID #:		Group #:
Is the insurance through your employer? If yes give company name:		
Effective date:		Termination Date:
Is this a Cobra Policy:	Monthly Premium:	
Copay or Coinsurance Information; $		
Benefit Information:		
Deductible: $	Stop Loss: $	Life Time Max:

This form has been designed for internal use of LIGHT of Southwest Florida only for determination of needs for assistance with costs related to treatment for cancer. By signing below you declare the information to be accurate and agree that LIGHT of Southwest Florida has your permission to verify any information you have provided.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________

SPOUSE SIGNATURE: ______________________________ **DATE:** ____________________

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20272 Leopard Lane
Estero, FL 33928

Name: ____
Address: ____County: ______________________
City, State, Zip Code: ____
Date of Birth: ________________ **Phone:** _____________________ **Cell Phone:** ___________________
Cancer Diagnosis:____
Approximate date of diagnosis: ____
Type of treatment you have received: ____
____
Future anticipated treatment required: ____
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You have applied for assistance with LIGHT of SW Florida, Inc. (Hereafter referred to as LIGHT) **for financial assistance related to your cancer treatment. In order to evaluate your needs, it will be necessary to verify the information you have provided. Please understand that it our intention to request sufficient documentation for this evaluation. LIGHT is asking that you look at the list below and provide LIGHT with copies of all pertinent documents. Please submit any additional documentation you feel supports your request for assistance.**

Copies of recent pay stubs for all household income
Copy of household expenses including: Monthly payments, insurance and tax information
Copy of recent utility bills
Copies of all monthly obligations
Bank statement Please include checking, saving and investment accounts
Copies of medical expenses: Please also include estimates for cost of any anticipated treatments relating to your diagnosis. Costs of prescription drugs should also be included.
Referral letter from treating physician verifying your diagnosis
Any other documentation you think will be useful in determining your current needs.

A brief letter explaining your current needs as they relate to your treatment and financial situation.

Your application for assistance will be reviewed by a committee of LIGHT and a determination will be done as quickly as possible. If the committee determines that financial assistance is appropriate, LIGHT will provide assistance directly to doctors, companies or institutions for your care and treatment. Payments will not be made to you directly. For direct assistance, LIGHT may be able to direct you to charities or foundations that can assist you further.

Please tell us how you heard of LIGHT:____
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