

 LUGHT of SW Florida, Inc.

12478 Green Stone Court

Fort Myers, FL 33913-6737

## PATIENT ASSISTANCE APPLICATION FORM

<b>Patient Information</b>			
Name		Date	
Address		U.S. Citizen?	<input type="radio"/> Yes <input type="radio"/> No
City, State, Zip		Social Security #	
County		Phone	
Date of Birth		Work Phone	
Email		Cell Phone	
Employer			
Employer Address			
Race	<input type="radio"/> White (non-Hispanic) <input type="radio"/> Hispanic <input type="radio"/> Black <input type="radio"/> Asian or Pacific Island <input type="radio"/> American Indian or Alaskan Native <input type="radio"/> Other		

<b>Spouse Information</b>			
Name		U.S. Citizen?	<input type="radio"/> Yes <input type="radio"/> No
Address		Phone	
County		Work Phone	
Date of Birth		Social Security #	
Employer			
Employer Address			

<b>Dependent Information</b> <i>(Please list name and age of all dependents living at home)</i>			

<b>Debts and Obligations</b>			
Your Residence	<input type="radio"/> Own <input type="radio"/> Rent	Value, if Owner	\$
Estimated Equity	\$	Taxes & Insurance	\$
Mortgage or Rent per Month		\$	
Monthly Cost of Food	\$	Monthly Medications	\$
Medical Bills	\$	Utilities	\$
Name of Other Debt		Amount	\$
Name of Other Debt		Amount	\$
Name of Other Debt		Amount	\$
Name of Other Debt		Amount	\$
Name of Other Debt		Amount	\$

<b>Assets and Income</b>			
Name of your bank		Checking balance	\$
Savings balance	\$	Your monthly income	\$
Spouse monthly income	\$	Disability income	\$
Unemployment	\$	Investment income	\$
Other income source		Amount	\$
Other income source		Amount	\$
Other income source		Amount	\$

<b>Health Information</b>			
Cancer Diagnosis			
Date of Diagnosis		Diagnostic facility	
Current Physician 1			
Address			
City, State, Zip			
Phone		Email	

Current Physician 2			
Address			
City, State, Zip			
Phone		Email	
Current Physician 3			
Address			
City, State, Zip			
Phone		Email	
Please describe the treatment you have been receiving, or anticipate receiving:			

<b>Insurance Information</b>			
Insurance Company			
Address			
City, State, Zip			
Phone		Email	
Insurance ID #		Group #	
Insured thru employer?	<input type="radio"/> Yes <input type="radio"/> No	Cobra policy?	<input type="radio"/> Yes <input type="radio"/> No
Effective date		Termination date	
Monthly premium	\$	Copay amount	\$
Benefit information:			
Deductible	\$	Stop Loss	\$
Lifetime 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: \_\_\_\_\_

**Additional Documentation Requirements:**

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.

<b>Please tell us how you heard of LIGHT:</b>

**GENERAL RELEASE AGREEMENT**

**\*This form must accompany the Financial Forms to be considered for assistance\***

I, \_\_\_\_\_, with an address at \_\_\_\_\_, Florida, in connection with services provided by or received from LIGHT OF SOUTHWEST FLORIDA, INC. (LIGHT) agree as follows:

1. In consideration for the cost-free services received from or provided by LIGHT, I hereby specifically grant to LIGHT the ability and right to using my:

\_\_\_\_\_ First Name and/or Story

\_\_\_\_\_ Initials and/or Story

\_\_\_\_\_ Photo and/or Story

in letters, brochures and all other manner of publicity and/or provision of information in furtherance of LIGHT's Purpose and Mission, including specifically fund-raising activities.

2. In further consideration for the cost-free services received from or provided by LIGHT, I hereby and IRREVOCABLY AND UNCONDITIONALLY RELEASE LIGHT and its officers, directors, employees, representatives, attorneys, agents, successors, and assigns (collectively referred to as releases) from all manner of agreements, promises, liabilities, actions and causes of action and claims, which I ever had, now have, or hereafter may have or which my heirs, executors, or administrators hereafter may have, whether known or unknown and including without limitation, any and all claims relating in any way to LIGHT using my full name and story and/or initials and story and/or photographs and story in letters, brochures and all other manner to publicity in furtherance of LIGHT's Purpose and Mission, including specifically fund raising activities.

3. I further agree and promise not to bring suit or file any cause of action against LIGHT or permit or condone any such action by any other person on my behalf in any state or federal court of law or federal or state administrative agency regarding any of the rights I granted to LIGHT in Paragraph 1, above.

4. Amendments; Entire Agreement; Governing Law. This agreement may not be changed orally, only in a writing signed by both myself and the President of LIGHT. It contains the entire understanding between the parties and supersedes all previous agreements, if any, with respect to the subject of this Agreement. This Agreement shall be governed by Florida law.

5. I, \_\_\_\_\_, acknowledge and affirm that I am competent to review and enter into this General Release Agreement and that I have read and fully understand this Release Agreement.

**I HEREBY SIGN THIS AGREEMENT  
FREELY AND VOLUNTARILY,  
INTENDING TO BE LEGALLY  
BOUND BY MY SIGNATURE. Accepted and agreed to:**

\_\_\_\_\_ By: \_\_\_\_\_

Dated: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_