Greater Clermont Cancer Foundation
P O Box 443, Minneola, FL 34755-0443
www. gccf.us (352) 435-3202

FORM 2 - Financial Supplement Application - Cancer Screening & Tests

Applicant Information

Your Name _____ US Citizen? YES _____ No _____
Address _____
City _____ Zip _____ Email _____
Contact Phones: Cell _____ Home _____ Other _____
Patient's Employer: _____
Employer Address: _____ Phone: _____
Patient's Spouse Name: _____ Phone: _____
Spouse's Employer: _____ Phone: _____
Employer Address: _____

Patient Information

Patient Date of Birth: _____ Date of initial reccomendation: _____
Screening or test recommended: _____
Recommending Physician Name: _____
Hospital/Clinic: _____
Service Provider Requested?: _____
Cost of Cancer Screening or Tests?
Name & Phone numbers of other organizations you contacted for assistance:
1) _____
2) _____
3) _____
4) _____
5) _____

Case Manager or Patient Navigator will evaluate reasonable & customary costs of requested screening or testing. Other funding resources may need to be researched prior to grant funding,

Patient's Medical Coverage Information

Does the patient have medical coverage? _____ If Yes, indicate the type (check all that apply)
If Yes, please indicate type (check all that apply)
Private Insurance? Name _____ Group? _____ Individual? _____
Medicare Only? _____ Medicare + other supplemental? _____ Name _____
Medicare & Medicaid? _____ Full Medicaid? _____ Share of Cost Medicaid? _____ $ _____
Emergency Medicaid? _____ Medicaid pending? _____ Charity Care? _____
VA Program & Type _____ Are prescription drugs covered? Yes _____ No _____

Please attach a short written paragraph describing your request circumstances and need.

Signature: _____ Date: _____

MAIL COMPLETED APPLICATION TO GCCF, PO BOX 443, MINNEOLA, FL 34755-0443
A GCCF case manager will review your information and will contact the applicant requesting assistance. Funds are limited and based on availability.
All information is strictly confidential and is for GCCF use only.