



# Greater Clermont Cancer Foundation

P O Box 443, Minneola, FL 34755-0443 - Phone: (352) 435-3202

## FORM 2 - Financial Supplement Application - Cancer Screening & Testing

### 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

Screening or test recommended: \_\_\_\_\_  
 Patient Date of Birth: \_\_\_\_\_ Date of initial recommendation: \_\_\_\_\_  
 Recommending Physician Name: \_\_\_\_\_  
 Hospital/Clinic: \_\_\_\_\_  
 Physician/Hospital/Clinic Contact Phone: \_\_\_\_\_  
 Name & Phone numbers of other organizations you contacted for assistance:  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_  
 4) \_\_\_\_\_

### 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 \_\_\_\_\_

**Patient Navigator will evaluate reasonable and customary costs of requested screening or testing.**

**Other funding resources may need to be researched prior to grant funding.**

**Approved grants may be paid as direct payment to a service provider or as a reimbursement.**

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

**MAIL COMPLETED APPLICATION TO GCCF, PO BOX 443, MINNEOLA, FL 34755-0443**

***The Patient Navigator 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 and Patient Navigator use only.***