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.