Team Up Montana Funding Request

Team up Montana

Team Up Montana is a dedicated effort to raise awareness and funding for the fight against cancer in Western Montana. Our efforts are guided by our core values of **Compassion, Dignity, Justice, Excellence and Integrity.** If you would like to request our support, please complete the form below for consideration.

Due to the volume of requests we receive, not all submissions will be honored. Therefore, completion of this request form does not obligate Team Up Montana or the Providence Montana Health Foundation in any manner. Approval of a request represents a one-time assistance payment and does not in any way constitute a promise of future financial assistance. All information is held in the strictest confidence and is used only for the purpose of reviewing financial assistance needs.

Criteria

An approved request must meet the majority of the following criteria:

- The request is in accordance with the Providence Montana Health Foundation's mission
- Individual must be a current patient undergoing, or who has recently completed, cancer treatment
- Individual must live in Western Montana
- Individual's medical status must be confirmed by a health care professional
- Funds are limited and grants are based upon availability of funds and the applicant's need.
- Request is of a reasonable cost, mindful that these dollars come from our patients and community and are not to be considered as an on-going source of funds

Please be sure to:

- Answer each question or indicate if an item does not apply to your situation
- Sign and date the application
- Have your doctor, nurse, or social worker complete the Medical Information section
- Provide a phone number where you can be reached to answer any additional questions

Please return this application to:

Providence Montana Health Foundation
Attention: Janet Kaufman
502 W Spruce
Missoula, MT 59802
(406) 327-3128 **OR** Fax to: 406-327-3058.

Team Up Montana Funding Application

PERSONAL INFORMATION:	
Date:	Referred by:
Applicant's Full Name:	Spouse's Full Name:
Amount of Funding Requested:	Phone Number:
Address:	Date of Birth:
City: State: Zip:	Number of People living in your home:
Name & Address of your employer:	Name & Address of Spouse's Employer:
If you are applying on behalf of someone, please enter the following information: Your Name:____________________ Address:____________________ Phone number:____________________ Relationship to applicant: ____________________	
Type of Health Insurance (please check all that apply) □ Private □ Medicaid □ Medicare	□ VA Program □ Charity Care □ Other________________ □ None
For what purpose are you seeking financial assistance (please check all that apply): □ Medical expenses □ Housing □ Utility Costs □ Food Costs □ Transportation □ Other____________________	
Describe in as much detail as possible the purpose of your request (Please attach additional information if needed.)	

ASSISTANCE ASSESSMENT:

Have you previously applied for assistance from our Foundation? □ Yes □ No

If yes, please indicate the date(s) and outcome of your application:

Have you received any grants or financial assistance from any other group or entity in the last 12 months? □ Yes □ No

If yes, please provide the name(s) and the amount(s):

Please provide the name of your health care provider:

Please attach copies of the following:
□ Copies of bills that you are requesting assistance for
□ Signed Medical Verification or letter from your physician
□ Recent W-2, tax return or Social Security Benefits letter

AGREEMENT AND SIGNATURE:

Please read and sign below after you have carefully reviewed your completed application.

By signing this application, I confirm that I am solely responsible for the accuracy of information contained herein.

I grant permission to the doctors and medical professionals contained herein to discuss any information regarding my treatment, diagnosis, prognosis, etc. pursuant to the Authorization submitted with this Application

I understand that TEAM UP MONTANA will use any information obtained solely for the purpose of considering financial assistance to me and that all of my medical information will be held in strict confidence.

I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release, unless I sign a media release form.

Signature of Applicant: ____
Date____

If approved, would you be interested in "telling your story" about being helped by Team Up Montana? (Your answer will not affect the outcome of the approval process.)

□ Yes, please send me a media release form □ No, I am not interested at this time

Official Use Only:
Comments:

Amount Approved:

ED Signature:____ Date:______________________

Chairman Signature: ______________________________________ Date: ______________________

Medical Verification

For Grant Application to Team Up Montana Funds

Patient Name:______________________________________ Date of Birth:______________

HIPAA Authorization

I authorize ____________________________________(the "keeper of the Records") to disclose my protected health information relating to my care and treatment as requested below. I understand that signing this Authorization is voluntary and that my treatment may not be conditioned on the signing of this Authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to the Keeper of the Records. I understand that I cannot revoke this Authorization to the extent this Authorization has been relied upon. I understand that information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient. By signing below, I understand and acknowledge the following: I have read and understand this Authorization; I have been given a copy of this Authorization; I am authorizing the Keeper of the Records to use or disclose my health information to the persons and for the purposes identified in this Authorization; and if I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact the Keeper of the Records. A photocopy of this authorization shall be considered as effective and valid as the original. The information request by this Authorization may be received by Providence Montana Health Foundation, 900 N Orange Street, Suite 201, Missoula, MT 59802. The information is being requested for the purpose(s) of awarding a Team Up Montana grant for cancer patients. Unless revoked earlier, this Authorization will expire twelve months after the date of the patient's signature below.

Patient Signature:____ Date:_________________

This section is to be completed and signed ONLY by the Applicant's Doctor, Nurse or Licensed Social Worker.

Primary Cancer:____ Date of Diagnosis:______________________
Stage of Cancer:____
Is this a □ New Diagnosis or □ Recurrence Is the patient in active treatment? □ Yes □ No
If Yes, please indicate type of treatment: (please check all that apply)

□ Chemotherapy □ Radiation □ Surgery □ Bone Marrow/Stem Cell Transplant
□ Palliative Care □ Clinical Trial □ Hormonal □ Complementary/Alternative

If No, will post-treatment follow-up be required? □ Yes □No

Physician's Name:____

Address:____
City/State/Zip:____
Phone:________________________ Fax:___________________________

Signature of doctor, nurse, or social worker:____

Print Name/Title:____

Phone (if different from above:____