THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Patient Financial Assistance Application

This application is used to evaluate your eligibility for the University of Texas MD Anderson Cancer Center's Patient Financial Assistance Program. To ensure prompt review of your application, please complete all sections. **Do not leave blanks.** You must submit documents to confirm your identity, Texas residency for the past six continuous months, your citizenship status, all income and assets. We may request additional documents if necessary to complete your application.

Please Type or Print Clearly in Ink.

Medical Record/Referral Number:

Application Date:

1 PATIENT INFORMATION

Patient's Name:

Telephone Number:

Date of Birth:

Sex:

Texas Driver's License Number:

Marital Status:

_____ Single _____ Married _____ Widowed (*Year*_____)

_____ Separated (*Year*_____) _____ Divorced (*Year*_____)

***If Minor*, Parent/Guardian Name:**

Telephone Number:

Date of Birth:

Sex:

Texas Driver's License Number:

Marital Status:

_____ Single _____ Married _____ Widowed (*Year*_____)

_____ Separated (*Year*_____) _____ Divorced (*Year*_____)

Required Documents

A copy of your valid, current Texas Driver's License or other valid, current government photo ID.

If widowed or divorced in the last 24 months, please attach a copy of the divorce decree or death certificate.

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2 WHAT IS THE PATIENT'S CITIZENSHIP STATUS?

Please check the applicable document and attach a copy.

If a U.S. citizen:

- ☐ Valid U.S. Birth Certificate, valid Certificate of Birth Abroad, or valid Report of Birth Abroad
- ☐ Valid current U.S. Passport or Passport Card
- ☐ U.S. Citizen Identification Card
- ☐ Certificate of Naturalization or Individual Fee Register Receipt for application for New Naturalization or Citizenship Paper

If a Lawful Permanent Resident:

- ☐ I hereby attest that I am a Lawful Permanent Resident of the U.S.
- ☐ Valid current Resident Alien Card Effective Date: _____

(A conditional Lawful Permanent Resident Card is not acceptable.)

If a member of any of the following immigrant categories:
Asylee, refugee, Cuban/Haitian entrant, Amerasian Lawful Permanent Resident, victim of severe trafficking, alien whose deportation is withheld, Active Duty or Veteran U.S. Military/dependent, alien battered spouse of U.S. Military or Veteran.

- ☐ Court Order
- ☐ USCIS petition
- ☐ I-94 with appropriate stamp
- ☐ Military or Veteran Documentation
- ☐ USCIS grant letter
- ☐ Other documentation: _____

_____

STOP

If you are unable to prove that you are an American citizen, a Lawful Permanent Resident for at least five years, or worked for 40 quarters, or a member of one of the listed immigrant categories, contact your Patient Access Representative.

You likely do not qualify for assistance.

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3 WHERE IS THE PATIENT'S PRIMARY RESIDENCE?

Current Address: *(Physical Address, not P.O. Box)*

Address:

City: State: Zip Code:

County:

From Date: To Date:

Previous Address:

City: State: Zip Code:

County:

From Date: To Date:

(If less than six months, attach separate sheet showing previous addresses for the past six months)

Can you claim residency in another state? Yes / No
***If yes*, where?**

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Continued...

3 WHERE IS THE PATIENT'S PRIMARY RESIDENCE?

Required Documents

Please check the applicable documents and attach copies.

A. Proof that your primary residence has been in Texas for at least the past six continuous months – submit any ONE of the following:

- ☐ Your deed or recent property tax statement or receipt
- ☐ A lease with the applicant name
- ☐ Military ID
- ☐ Notarized letter from a homestead owner or lessor attesting to date when you moved there
- ☐ Notarized letter from a homeless shelter administrator showing when you began staying there

B. Proof you have resided in Texas for the past six months – submit any TWO of the following documents:

- ☐ Valid current Texas Drivers License or ID Card
- ☐ Valid current homeowner's/renter's insurance policy
- ☐ Valid current Texas Motor Vehicle Registration
- ☐ Utility bills in your name for the past six months
- ☐ Valid Current Texas Voter Registration
- ☐ Bank statements/cancelled checks for the past six months
- ☐ Notarized letter from Texas employer on company letterhead showing dates and location of employment
- ☐ Proof of Texas public benefits *(food stamps, etc.)* for the past six months
- ☐ Proof of Texas public or private school enrollment *(if the patient is a child)* for the past six months
- ☐ Approved registration for Texas city or county health care benefits for the past six months
- ☐ Proof of in-state tuition benefits for the past six months
- ☐ Child's immunization records *(if the patient is a child)* for the past six months

If you are unable to prove that you have resided in Texas continuously for the past six months, contact your Patient Access Representative.

You likely do not qualify for assistance.

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4 DOES THE PATIENT HAVE INSURANCE OR OTHER COVERAGE?

STOP

Please circle all that apply.

Failure to disclose coverage or dropping coverage may result in the denial of your application.

Texas Medicaid? Yes / No
Texas Medicaid patients do not have to complete this application.

Traditional Medicare? Yes / No
Circle current enrollments – Part A Part B Part D

Medicare Advantage Plan? Yes / No
If yes, Insurance Name:

HMO, PPO, or Indemnity Insurance? Yes / No
If yes, Insurance Name:

COBRA or COBRA-eligible? Yes / No
If yes, COBRA enrollment is required.

Active Duty Military or Dependent? Yes / No
If yes, Insurance Name:

Veterans Administration Benefits? Yes / No

Cancer Policy? Yes / No
If yes, Name:

5 ELIGIBILITY ASSISTANCE PROGRAM

This screening is required for all applicants.

You may be eligible for additional assistance from third party programs such as Medicaid or county programs. Please contact 713-563-0280 or 1-855-236-5678 to learn if you qualify. There is no charge to you for this service.

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6 EMPLOYER

Patient or Legal Guardian Employer:

Employer Name:

Address:

Telephone:

Position Held:

Spouse Employer Name:

Address:

Telephone:

Position Held:

7 FAMILY SIZE

Do not list the patient (attach additional pages if necessary).

Please list everyone who the patient is legally responsible for including spouse and dependents. If separated for less than 24 months, include spouse. If separated for 24 months or more, do not include spouse if you can show separate addresses, financial accounts and income tax returns.

Name:	Relationship to Patient:	Family Income Contributor?	Age:	Student?
		Yes / No		Yes / No
		Yes / No		Yes / No
		Yes / No		Yes / No

List everyone who is legally responsible for the financial support of the patient, including those who claim the patient as a dependent or tax credit.

Name:	Relationship to Patient:	Family Income Contributor?	Age:
		Yes / No	
		Yes / No	

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8 ASSETS

Please complete for the patient and everyone listed in Family Size section. Enter a zero for anything that does not apply.

Banking Information:

	Account No:	Institution Name:	Date:	Current Balance:
Checking				$
Savings				$
CD				$

***A. *Checking/Savings/CD* Total:** $

Stocks/Bonds/Other Securities and/or Trusts:

Account No:	Institution Name:	Date:	Current Balance:
			$
			$

**Attach additional sheets if necessary and include in total.*

***B. *Securities* Total:** $

Equity Value of Real Estate/Property other than Primary Residence *(County Appraisal District market value minus the mortgage)*:

Current Balance:
$
$

C. *Equity* Total: $

Oil Lease Royalties *not included on income tax return*

D. *Royalties* Total: $

Value of assets transferred to another person(s) since you have been diagnosed with cancer:

E. *Transferred Assets* Total: $

Other Assets *not included on income tax return:*

***F. *Other Assets* Total:** $

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Continued...

8 ASSETS

Required Documents

Please check all that apply & submit copies for the patient and everyone listed in Family Size section.

- ☐ Bank statements - 3 most current months
- ☐ Certificate of Deposit statements - 3 most current months
- ☐ County Tax Appraisal for property other than Primary Residence
- ☐ Securities statements (stocks/bonds/other) - last quarter
- ☐ Mortgage Statement for property other than Primary Residence
- ☐ Most Recent Trust Bank Statement
- ☐ Oil Lease Royalties not included on income tax return
- ☐ Personal value of property held in common ownership
- ☐ Statements pertaining to all other assets listed above

9 FAMILY INCOME

Please complete for the patient and everyone listed in Family Size section.

Does anyone claim the patient as a dependent or tax credit? Yes / No

***If yes,* who?**

Did the patient/spouse/guardian file a U.S. FEDERAL INCOME TAX RETURN? Yes / No

***If yes,* (year)**

***If no,* please submit a IRS non-filing statement.**
To obtain a statement, please contact the IRS at 1-800-829-1040 or visit www.irs.gov

FILING STATUS:
Single or Married Filing Jointly or Head of Household or Qualifying Widow with Dependent Child:
Adjusted Gross Income:

$

Married Filing Separately:
Patient Adjusted Gross Income:

$

Spouse Adjusted Gross Income:

$

Total Monthly Living Expenses:

$

Patient Financial Assistance Application

Continued...

9 FAMILY INCOME

Is monthly Adjusted Gross Income less than total monthly expenses? Yes / No

***If yes,* state how expenses are being met:**

Monthly amount of funds you receive to help you meet expenses:

$

Check all the following that apply to anyone listed in the family section of the application:

- ☐ Business
- ☐ Partnerships
- ☐ Royalties
- ☐ Farms
- ☐ Rental Income
- ☐ S Corp

***If an item is checked,* please submit a Profit & Loss Statement for last fiscal year or past 12 months prepared by a CPA or ask the patient access staff for the Small Business Income Statement Form to complete.**

Required Documents

Please check all that apply & attach copies.

If married or separated for less than 24 months, please provide for both the patient and the patient's spouse.

- ☐ U.S. Individual Income Tax Return - Form 1040, 1040 EZ, etc., with W-2 and all Schedules and attachments for the most recent year.
- ☐ IRS Statement of Non-Filing if U.S. Individual Tax Return was not completed
- ☐ Paycheck stubs or payroll records for the past 3 months if you filed an income tax return or last 12 months without an income tax return
- ☐ Social Security Earnings Statement or most recent Social Security Award Letter
- ☐ Disability earnings statement *(most recent)*
- ☐ Unemployment Compensation for the past 12 months
- ☐ Statements of interest income and capital gains distributions *(most recent)*
- ☐ Alimony and Spousal support for the past 12 months
- ☐ Income statements from IRAs, pensions, annuities or any source for the past 12 months if not reported on Income Tax Return
- ☐ Documentation of all other income for the past 12 months that is not listed above *(housing or vehicle allowance/stipend, insurance or estate distributions, winnings from gambling or lotteries, court judgments and earnings from any other source)*

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10 CERTIFICATION

The patient or parent/ guardian must sign this Certification.

I understand that this assessment may not be processed until all required information is submitted. I understand that additional information may be required to process my application.

I certify that the information provided in this assessment is complete and accurate to the best of my knowledge. I agree to notify MD Anderson Cancer Center of any change in my insurance eligibility or financial status. I authorize MD Anderson Cancer Center to verify all submitted information.

I understand that if any information that I have submitted is found to be inaccurate, false, or misleading, any assistance that may have been approved will be rescinded, I will be responsible for all charges incurred as of my first date of service, I will be required to pay in advance for any future services, and I may risk discontinuance of services and/or legal action.

Applicant Signature:

Print Name:

Date:

Relationship to Patient:

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Pharmacy Patient Assistance Programs Authorization for Disclosure of Health Information

(1) **I hereby authorize** MD Anderson Cancer Center to disclose or release the following information from the health records of (see below) for the purpose of enrollment into pharmaceutical Patient Assistance Programs or to seek reimbursement assistance for medications in the event that I require prescription assistance.

Patient Name: _____ **Date of Birth**: _____

Address: _____ **Telephone**: _____

_____ **Patient Number**: _____

This authorization will be active covering all periods of healthcare while receiving medications.

(2) **Information to be disclosed**:

- Medication records
- Progress Notes
- Laboratory tests
- Chemotherapy Notes
- Financial records
- Demographic records
- Insurance coverage

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing, if such information is included in my records.

(3) **This information is to be disclosed to:** One or more of the pharmaceutical manufacturers or contractors listed on the second page of this form, or other pharmaceutical manufacturers or contractors that may participate in pharmacy patient assistance programs (as added to this list on an annual basis).

(4) **I understand that this authorization may be revoked** in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will be in effect for the length of participation in the program + 5 years. Contact: Department of Pharmacy Financial Services, 1400 Holcombe Blvd., FC2.3062, Houston, TX 77030-4008

(5) **I understand that my treatment at MD Anderson will not be affected** if I decide not to sign this authorization. However, it will become my responsibility to pay for the treatment.

(6) **I understand that information disclosed** pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: _____ _____
(Patient) (Date)

_____ _____
or (Personal Representative) (Relationship to Patient) (Date)

Pharmaceutical company or contractor contact information:

- Amgen Safety Net Foundation
- Astellas Reimbursement Services
- AZ & Me Prescription Savings for Healthcare Facilities
- Biovitrium
- Bristol- Myers Squibb Patient Assistance Foundation, Inc.
- Celgene Patient Support
- Cephalon Oncology Reimbursement Expertise (CORE)
- Eisai Patient Assistance Program
- Eli Lily
- Genentech Access to Care Foundation
- Glaxo Smith Kline (Commitment/Bridges to Access)
- Janssen Ortho PAF Hospital Access PAP
- Merck ACT Program
- Millenium
- Nexavar Reach Program
- Novartis Patient Assistance Program
- Pfizer First Resource
- Pfizer RSVP
- Sanofi Patient Connections