

Pardee Cancer Treatment Fund of Clare County

212 W. Sixth St.

PO Box 65

Clare, Michigan 48617

Ph: 989-802-5225

Enclosed is a copy of our Pardee Cancer Treatment Fund of Clare County application. Please sign, complete enclosed and attach the additional information below and return by mail as soon as possible.

Please include:

- Completed application
- Copy of 2025 Federal income tax if required to file.
- Copy of most current bank statements (checking and savings).
- Copy of driver license or ID.
- Copy of medical insurance cards.

If you have any questions, please do not hesitate to contact our office. 989-802-5225.

Thank you,

Peggy & Tammy
Clare Pardee Treatment Fund

**PARDEE CANCER TREATMENT FUND
PATIENT INTAKE FORM**

DATE: _____

PATIENT INFORMATION						
LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH	AGE
Address			CITY	STATE	ZIP CODE	COUNTY
SEX	HOME PHONE		CELL PHONE		HOW MANY YEARS LIVED IN COUNTY	
EMAIL ADDRESS			MARITAL STATUS		SOC SECURITY NUMBER (Last 4 Digits)	
INSURANCE INFORMATION						
DO YOU HAVE INSURANCE ☐ YES ☐ NO		PRIMARY CARD HOLDER ☐ SELF ☐ SPOUSE ☐ OTHER		PRIMARY POLICY HOLDER NAME		
PRIMARY INSURANCE COMPANY		PRIMARY ID NUMBER		PRIMARY GROUP NUMBER		
DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO		SECONDARY CARD HOLDER ☐ SELF ☐ SPOUSE ☐ OTHER		SECONDARY POLICY HOLDER NAME		
SECONDARY INSURANCE COMPANY		SECONDARY ID NUMBER		SECONDARY GROUP NUMBER		
SUPPORT PERSON						
LAST NAME		FIRST NAME		CELL PHONE		
DIAGNOSIS						
Diagnosis						
Physician's Name 1						
Physician's Name 2						
Physician's Name 3						
PREFERRED PHARMACY						
Pharmacy Name						
NOTES						

If you have changes in your income, residence, phone, insurance or any other information on this form prior to your yearly update, we request that you report any and all changes to our office as soon as possible. The Pardee Cancer Treatments Fund attempts to update patient information on an annual basis.

PARDEE CANCER TREATMENT FUND
PERSONAL FINANCIAL STATEMENT

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
ADDRESS		CITY/STATE/ZIP CODE	HOME PHONE
CELL PHONE	LIFE INSURANCE COMPANY (IF APPLICABLE)		SOCIAL SECURITY NUMBER (Last 4 Digits)

SPOUSE OR SIGNIFICANT OTHER INFORMATION				
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY (Last 4 Digits)
ADDRESS (if different from patient's)		CITY/STATE/ZIP CODE	PHONE NUMBER	

HOUSEHOLD MEMBERS			
Name	Relationship to Patient	Date of Birth	Employer (if applicable)
	SELF		

⬆ Please List all people living in the household, including applicant (use additional paper, if needed) ⬆

MONTHLY HOUSEHOLD INCOME				
		Person 1: (SELF)	Person 2:	Person 3:
Employment		\$	\$	\$
Self-Employment		\$	\$	\$
Pensions		\$	\$	\$
SSI/SSDI		\$	\$	\$
Child Support		\$	\$	\$
Alimony		\$	\$	\$
Real Estate Rentals		\$	\$	\$
Unemployment since (/ /)		\$	\$	\$
Other Income		\$	\$	\$
Retirement	Social Security	\$	\$	\$
	Pension	\$	\$	\$
	Annuity	\$	\$	\$
Total: \$			Total: \$	Total: \$

SAVINGS AND INVESTMENTS			
Checking Acct Balance	\$	\$	\$
Savings Acct Balance	\$	\$	\$
CD Account Balances	\$	\$	\$
IRA's, 403B, 401K Balances	\$	\$	\$
Stock Balances	\$	\$	\$
Life Insurance Cash Value	\$	\$	\$
Other	\$	\$	\$

PARDEE CANCER TREATMENT FUND
PERSONAL FINANCIAL STATEMENT

MONTHLY HOUSEHOLD EXPENSES					
Mortgage	\$	Water	\$	Child Care	\$
Rent	\$	Grocery	\$	Dental Bills	\$
Car Loan(s)	\$	Cable/Internet	\$	Other Loans	\$
Gas for Auto	\$	Cell Phone	\$	Alimony/Child Support	\$
Electric/Gas	\$	Propane or Wood Heat	\$	Doctor/Medical Bills	\$
Telephone	\$	Prescription Meds	\$	Dental Insurance Premium	\$
Charities/Church	\$	Non-Prescription Meds	\$	Life Insurance Premiums	\$
Total Credit Card(s)	\$	Property Tax	\$	Health Insurance Premium	\$
Auto Insurance	\$	Home Owners Insurance	\$	Other	\$

If an item is an annual expense, rather than monthly, calculate what the monthly cost would be.

Total: \$

HOMESTEAD INFORMATION		☐ N/A
MORTGAGE BALANCE	MORTGAGE PAYMENT	
NAME OF MORTGAGE HOLDER	HOME VALUE	

LIST OF ALL OTHER PROPERTIES
For example: Land, Vacation Homes, Rentals, etc.

VEHICLES
Make/Model/Year and approximate value/loan balance.

OTHER ASSETS
Tools/Equipment, Watercraft, Business Assets, Jewelry or items not reflected elsewhere.

1. I certify that the above information is true and accurate to the best of my knowledge. I understand that any incorrect or false information could cancel my application for financial assistance.
2. I will apply for any and all assistances which may be available through federal, state or local government and private sources to help pay my medical bills.
3. I understand that the information submitted is subject to verification by Pardee and may be reviewed by federal and/or state agencies and others as required.
4. I authorize release of all medical, financial, billing and insurance information to Pardee as needed.
5. I understand that a tax return will be needed to process this application and that more information may be requested before my eligibility can be determined.

Applicant Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

PARDEE CANCER TREATMENT FUND
RELEASE OF MEDICAL INFORMATION FORM & SOCIAL SECURITY PRIVACY ACT

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

Last Four Digits of Social Security Number: _____

I authorize the release of information or records specified in this Release of Medical Information, including my individually identifiable health information and medical and billing information described below, to the Pardee Cancer Treatment Funds of Midland, Gladwin, Arenac County, Bay County, Clare County, Gratiot County and Isabella County (collectively "Pardee") as needed in conjunction with my application for Pardee assistance.

Records Authorized to Be Released to Pardee: I consent to and authorize the release of all of my medical, pharmaceutical, financial, billing and insurance information, along with any explanation of benefits (EOBs) and physicians' case report card. Such records may include, but are not limited to: admission history and physicals, discharge summary, complete hospital chart, office notes, outpatient records, lab reports, radiological images, consultation notes or reports, complaints or grievances filed with responses or dispositions, medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (in this instance, these records should be redacted to protect information pertaining to other patients.) It is my intention through this release, in accordance with the privacy rules described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, to grant to Pardee the same ability to access my medical records as I would myself, as well as the ability to disclose such information to others as described below.

Records Authorized to Be Released by Pardee to Provider: I consent/authorize the release of all of my personal financial information and records in Pardee's possession to any medical provider of mine in order to inform the provider of my financial situation. Such financial information and records may include, but not be limited to: financial, billing and insurance information with explanation of benefits (EOBs).

- I understand that I may revoke this authorization and request for release at any time by submitting my revocation in writing to the entity providing the information and by present my written revocation to Pardee office. Revocation of this authorization and request for release will not apply to information that has already been released by my health care providers.
- I understand that authorizing the disclosure of this health information is voluntary. I understand that I need to sign this form in order to ensure consideration of payment by Pardee on my medical bills.
- I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the staff at my local Pardee office.

A copy of this authorization may be utilized with the same effectiveness as an original. Social security numbers are confidential and Pardee uses only last four digits to confirm patient identity when absolutely necessary. All patient documents are shredded if disposal is necessary for your privacy.

Signature of Client or Legal Representative/ Relationship to Client

Witness

Expires 12 months from this date.

Date

Revised September 2025