Pardee Cancer Treatment Fund Application Checklist

Please find enclosed the paperwork for the Pardee Cancer Treatment Fund client application process. Below is a list of additional documentation necessary to be considered:

- ☐ **Copy of your driver's license**
- ☐ **Copy of health insurance card(s)**
  - List of deductible/coinsurance/copay/out of pocket amounts

Proof of Income

- ☐ **Proof of current rent amount** OR **mortgage statements** from lender
  - Must include balance due for mortgage statement.
- ☐ **Current proof of income for ALL household members**
  - For example: month paystubs, pensions, unemployment, etc.
- ☐ **Last complete filed tax return** or W-2s if you are not required to file annually
- ☐ **Bank statements from the last three months for each/any accounts you have.**
  - Statement must include bank name and account holder name
- ☐ **Complete statements for all investments** (CDs, IRAs, 401Ks, Stocks, etc.)
  - Must include all pages of statements.
- ☐ Current Medicaid spend down/ Medicaid eligibility/ food stamps letters
- ☐ Social security and/or disability benefit amount letter

Pardee Forms

- ☐ Patient Intake Form
- ☐ Financial worksheet
- ☐ Signed forms/consent (i.e., HIPAA, Demographics sheet, Rights and Responsibility Sheets)
- ☐ Signed Policy and Guidelines

<u>Please include any Paid and unpaid cancer related medical bills (from the last 3 months)</u>

The Gratiot County Pardee Board of Directors meet monthly to review all the new client requests. In order to be considered and start receiving financial support, all completed paperwork is required at the time of submission.

The next board meeting is . Please try to complete all required documents (listed above) a week before in order to be considered and start receiving financial support.

Sincerely,

Pardee Cancer Treatment Fund Gratiot County Client Coordinators

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

PARDEE CANCER TREATMENT FUND OF GRATIOT COUNTY

PATIENT POLICIES AND PROCEDURES

Requirements to Participate in the Pardee Benefits

1) You must have a current cancer diagnosis, or are still receiving cancer treatment.
2) You must have financial need for assistance.
3) You must have been a legal resident of Gratiot County for at least one year. You become ineligible if residence is taken outside of Gratiot County, or if you reside out of state for more than six months of the year.
4) You must complete an application, financial statement, Medical Release (HIPAA) form and provide all necessary financial documentation. All submitted information MUST be true and accurate of the applicant.

Guidelines and Policies

1) **Consideration of application:** We will hold your application until all supplemental documentation required is received. Your case will be taken before the Pardee Board for acceptance or denial. The board meeting is held the second Thursday of each month.
2) **When Pardee support ends:** Pardee will cover client costs during their time of treatment and for one-year following their remission.
3) **Prescriptions:** Pardee will pay your prescription copays at 100% and other cancer-related bills at a discount. The health care provider may accept the discount or may choose to bill you directly for the remaining balance.
    a. Meijer's Pharmacy drug accounts are available but must be set up by Pardee first. This will allow you to pick up your drugs and have the prescription or co-payment billed directly to Pardee.
4) **Equipment:** If equipment, a wig, prosthesis, bra, oxygen, etc. is needed, you must obtain prior approval before charging these items to Pardee. Without prior approval, you will be billed for the balances. (Some limitations do apply)
5) **Seek additional financial support:** Applicant must exhaust all insurance coverage and hospital financial assistance options before Pardee will be able to help. Pardee is a third-party that assists with leftover balances <u>after</u> insurance has paid.
6) **Mileage and Lodging Reimbursement:** Patients will be reimbursed $0.25 a mile up to a maximum of $1,500.00 for both lodging and/or mileage per year. Receipts for lodging and signatures of the healthcare provider visited will be needed to verify the appointments and/or treatments.
7) **Items not eligible for benefits from Pardee:** Balances under $25, insurance deductibles, experimental drugs, bills from the previous year, private rooms, other persons meals, home nursing care, drug consults or phone consults, food supplies or medical bills related to other problems.
8) **Services not eligible for benefits from Pardee:** Pardee will **NOT** cover ambulance charges or co-pays for ambulances.

PARDEE CANCER TREATMENT FUND OF GRATIOT COUNTY

PATIENT POLICIES AND PROCEDURES

Please initial each listed policy and sign at the bottom.

_____ **COMMUNICATE PARDEE APPLICATION TO PROVIDER:** It is my responsibility to inform doctors, hospitals and all medical service providers that are treating me for my cancer that I have applied to Pardee for assistance.

_____ **SUBMIT BILLS TO PARDEE**: I must turn in bills to Pardee when I receive them, either by dropping off at the office or by mailing them into the office. DO NOT STOCKPILE THE BILLS.

_____ **ENROLL IN SUPPLEMENTAL MEDICARE:** If I am a Medicare eligible recipient, I must be enrolled in Medicare parts A, B and D.

_____ **PROVIDE EOB:** I must provide Pardee with the explanation of benefits (EOB) for a bill if requested.

_____ **APPLY TO MEDICAID, MEDICARE, OR MARKETPLACE IF UNINSURED:** If you do not have insurance, you can apply through the Department of Health and Human Services. Pardee would need copy of approval or denial letter, if applicable.

_____ **PARDEE WILL NOT PAY A BILL IN COLLECTIONS:** I understand that once a bill goes into collections, Pardee cannot pay on the bills.

_____ **DO NOT DROP INSURANCE WITHOUT TALKING TO PARDEE FIRST.** You must contact Pardee if you are in jeopardy of losing your insurance due to lay-offs, possible job loss, employer dropping insurance coverage

_____ **REPORT CHANGES:** I must inform Pardee of any changes in my situation as they occur.

- Changes in household employment, income, retirement, unemployment benefits, etc.
- New address, changes in phone number, added new mortgage or refinanced mortgage, etc.
- Insurance changes, Medicaid (Including deductible changes), going on Medicare, your employer changed insurance companies, etc.

_____

Signature of Client or Legal Representative/ Relationship to Client

_____

Date