2019 Patient Request for Financial Navigation

Confidential Personal Information Sheet

All sections are required. Please fill out completely

NEW DAY FOUNDATION
FOR FAMILIES FIGHTING CANCER

TAILORMED

Today's Date: _____

PATIENT INFORMATION

Full Name _____
Last First Middle

Street Address _____

City, State _____ Zip _____

Phone: Home _____ Cell _____

Email _____ Age _____ Date of Birth: _____

Marital Status: *(circle one. If minor, input parental status.)*
Single Married Divorced Cohabitants Widowed Separated Other

Gender _____

Number of people in your household _____

MEDICAL INFORMATION *(To be completed and signed by social worker, patient advocate, nurse or physician)*

Hospital _____ Hospital Location (City/State) _____ NPI _____

Physician Name _____ Phone: _____

Social Worker Name _____ Phone: _____

Social Worker Email Address _____

Date of Diagnosis _____ Primary Cancer _____ ICD Code _____

Is patient in active treatment? *(circle one)* Y / N

Treatment start date _____ Projected treatment end date _____

If in active treatment, please indicate type of treatment _____

Do you give New Day Foundation representatives permission to speak directly with your physician(s)? Y / N

INSURANCE INFORMATION

Primary Insurance _____ Member ID: _____

Plan Type (Circle one): Original Medicare Medicare Advantage Medicaid Medicare Supplemental (Medigap)
Medicare Part D ACA Plan Employer Commerical Tricare VA

Full name of the policy owner _____ Date of Birth _____

Secondary Insurance _____ Member ID: _____

Plan Type (Circle one): Original Medicare Medicare Advantage Medicaid Medicare Supplemental (Medigap)
Medicare Part D ACA Plan Employer Commerical Tricare VA

Full name of the policy owner _____ Date of Birth _____

Tertiary Insurance _____ Member ID: _____

Plan Type (Circle one): Original Medicare Medicare Advantage Medicaid Medicare Supplemental (Medigap)
Medicare Part D ACA Plan Employer Commerical Tricare VA

Full name of the policy owner _____ Date of Birth _____

INCOME INFORMATION

Annual household income _____

TREATMENT DETAILS

TAILORMED

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DRUG REGIMENS – MANDATORY

Regimen Name	# of Cycles	Start Date	Administration Site *(Outpatient, Clinic or Self)*	Provider

DRUG EVENT – MANDATORY

Drug Name	How Administered?	Dosage	# of Cycles	Start Date	Administration Site *(Outpatient, Clinic or Self)*	Provider

RADIOTHERAPY EVENT

Type *(IMRT, IGRT, 3D, Conformal, Int. Radiation, or Ext. Radiation)*	# of Fractions	Provider

IMAGING

Type *(CT, Xray, MRI, US, PET-CT, or Other)*	Imaging Area	With or Without Contrast?	Date	Provider

VISIT

Types *(Specialist, PCP, or Other)*	Date	Provider

OTHER

Treatment	Date	Provider

FINANCIAL ASSISTANCE

Is Patient currently enrolled in any of the following assistance programs? (check all that apply and provide details below)

❑ Premium Assistance ❑ Lodging ❑ Transport

❑ Copay Assistance ❑ Living Expenses

Name	Enrollment Date	Amount

PATIENT NEEDS (CHECK ALL THAT APPLY):

❑ Medical ❑ Copay Assistance ❑ Premium Assistance

❑ Non-Medical ❑ Transportation ❑ Lodging ❑ Living Expenses

❑ Other: _____

SPECIAL ENROLLMENT

Did you or anyone in your household lose qualifying health coverage in the past 60 days OR do you expect anyone in your household to lose coverage in the next 60 days?

❑ Yes ❑ No

Did any of the following apply to you or anyone in your household in the past 60 days?

Changes In Household Size:

❑ Got Married ❑ Had a baby ❑ Gained/became a dependent ❑ Death

❑ Got divorced or legally separated and lost health insurance

Changes in Residence or Income

❑ Changed your primary place of living ❑ Had a change in income

Changes in Status

❑ Denied Medicaid/CHIP

❑ Gained citizenship or lawful presence in the US

❑ Was released from incarceration (detention, jail or prison)

Are you a member of a federally recognized tribe, or an Alaska Native corporation shareholder?

❑ Yes ❑ No

AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby authorize New Day Foundation and its business associate TailorMed Medical Ltd., to use and/or disclose individually identifiable health information provided on this application for the **sole purpose of conducting a financial navigation review and/or perusing a grant or assistance program to cover part or all of my medical** bills, general expenses and insurance premiums. I also understand that, if the authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Below is a list of organization that might be receiving the Information:

_____ _____

Patient or Patient's Legal Guardian Date

In Honor of Matt Kell & Cathy Spehn

www.FoundationForFamilies.org