



PATIENT ASSISTANCE APPLICATION
(FOR PATIENTS 400% OR BELOW FEDERAL POVERTY GUIDELINES)

NUMBER IN HOUSEHOLD (INCLUDING SELF): _____

HOUSEHOLD MONTHLY INCOME		
	SELF	SPOUSE
WAGES	\$	\$
SELF-EMPLOYMENT	\$	\$
PUBLIC ASSISTANCE	\$	\$
SOCIAL SECURITY	\$	\$
UNEMPLOYMENT COMPENSATION	\$	\$
WORKMEN'S COMPENSATION	\$	\$
ALIMONY	\$	\$
CHILD SUPPORT	\$	\$
MILITARY FAMILY ALLOTMENTS	\$	\$
PENSIONS	\$	\$
INCOME FROM DIVIDENDS, INTEREST, RENT	\$	\$
HEALTH INSURANCE OR COBRA PAYMENT	\$	\$

****PLEASE FAX THIS APPLICATION WITH FINANCIAL RECORDS TO VERIFY INCOME****

PATIENT ASSISTANCE REQUESTED:

- _____ CO-PAY INSURANCE ASSISTANCE (PATIENT MUST HAVE INSURANCE TO QUALIFY)
- _____ TRANSPORTATION - ACS ROAD TO RECOVERY **MUST** BE USED FIRST. PATIENT TREATMENT SCHEDULE **MUST** BE FAXED TO THE OFFICE
- _____ GENETICS TESTING (CMDX)
- _____ INSPIRITAS SPA

PERSON FROM PHYSICIAN'S OFFICE COMPLETING APPLICATION: _____

PHYSICIAN NAME: _____ PHONE: _____

PHYSICIAN MAILING ADDRESS: _____
CITY/STATE/ZIP CODE

PRACTICE NAME: _____ TAX PAYER I.D. NUMBER: _____

FOR OFFICE USE ONLY _____

HH SIZE: _____ TOTAL HH INCOME: _____ AFIG: _____

DATE ENTERED (EXCEL): _____ NOTES: _____



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DIAGNOSIS: _____ DATE OF DIAGNOSIS: _____

TREATMENT NEEDED: _____ CHEMOTHERAPY _____ RADIATION

START DATE: _____ END DATE: _____

IS PATIENT AMBULATORY? _____ YES _____ NO; IF NO, IS PATIENT IN A WHEELCHAIR? _____ YES _____ NO

WILL PATIENT HAVE A COMPANION ACCOMPANYING THEM TO TREATMENT? _____ YES _____ NO

ACS TRANSPORTATION END DATE? _____

TRANSPORTATION START DATE: _____

ADDRESS OF TREATMENT CENTER: _____

CONTACT PERSON AT TREATMENT CENTER _____

PHONE NUMBER: _____ FAX NUMBER: _____

Have a question? Call the office at (210) 593-5949

Completed form must be faxed to (210) 593-5705

****Please give two business days to process paperwork****