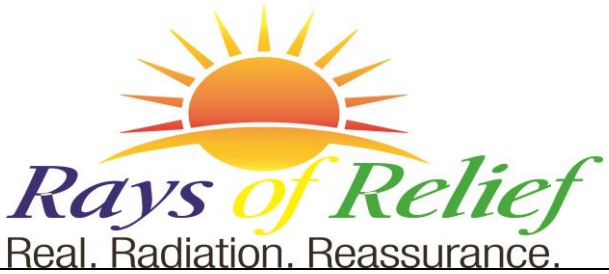


Patient Assistance Application (threshold at 500% above FPL)
For minors under the age of 18 (legal guardian/parent/conservator income is required)

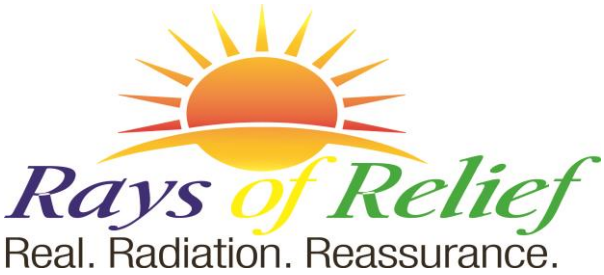
Name:	Date of Birth:	SSN:
Home Address:		

Household Size	Adults	Children		

Home Phone	Cell Phone	Work Phone

Current Employer	If No Longer Working Last Date of Employment

Total Household Income	Self	Spouse
1.Salaries/wages after taxes (adjusted gross income)		
2. Business Income		
3. Rental Income		
4. Investment Income		
5. Alimony		
6. Child Support		
7. Social Security		
8. Public Assistance		
9. Disability		
10. Pension		
11. Other Income (list amount /source)		



To be completed by treating facility staff (Financial Counselor/RN/LVN)

Treating Physician: _____

Physician Signature: _____

Treating Facility (current DBA/doing business as) :

_____

Facility TIN (Tax ID number): _____

Facility Address (City/State/Zip Code): _____

Facility Payment Address: _____

Office Contact: (person completing form) _____

Direct number: _____

Email Address: _____

Patient Diagnosis: _____

Date of Diagnosis: _____

Patient Gender: _____

Staging: _____

Patient Race: _____

Patient Ethnicity: _____

Treatment start/end date (anticipated): _____

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Patient Authorization for release of PHI (protected health information)

I authorize the use and disclosure of my individually identifiable health information ("Protected Health Information") by Rays of Relief, a Texas 501c3, to process my application for the Patient Assistance Program and complete my enrollment if I am eligible per FPL (federal poverty level) guidelines. Funding as available will be allocated for me and paid out to the treating facility.

I authorize my health care provider to disclose to Rays of Relief my health information verbally or written to be used for the purposes stated above. I understand that my Protected Health Information may be subject to re-disclosure pursuant to this authorization. I may withdraw this authorization by mailing or faxing a letter of revocation to Rays of Relief, but if I do, wit will not have an effect on any actions Rays of Relief took before it received revocation of this Authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through this program. This authorization has no expiration date.

Agreements

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. **I understand that my application for assistance does not guarantee funding will be available.** I understand that if I am awarded financial assistance that it will be provided on a calendar year basis and that I must reapply each calendar year. There is no guarantee that funding will be available in the subsequent year.

_____ _____

Signature (Patient/Legal Guardian/Medical Power of Attorney) Date

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Insurance Company: _____

Insurance ID: _____

Effective Date: _____

Coverage breakdown 70/30 80/20 85/15 90/10 95/5 other (please circle one)

Does patient have daily radiation copays? _____

Daily radiation copay amount? _____

Estimated Out of Pocket for patient regimen? _____

Regimen type: Number of fractions: _____

(I.E. Electrons/2D/3D/ IMRT/HDR/etc.) _____

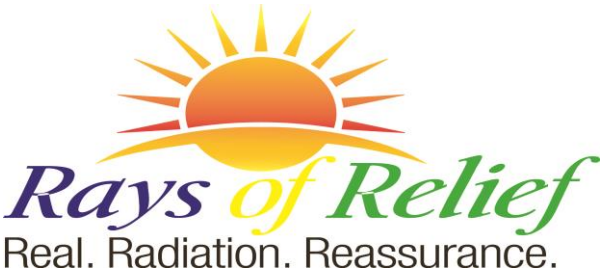
Is patient currently receiving any other assistance? (i.e. Healthwell/Cancer Care/ PAN/PAF/PINK FUND/THE ASSISTANCE FUND/PSI/NORD/ Pharma Copay Card)

_____

*** Please provide copies of current insurance cards (front/back) as well as radiation CT SIM order with number of estimated fractions for the regimen.**

ACCEPTABLE PROOF OF INCOME: ANNUAL 1040/1099, 4 CONSECUTIVE CHECK STUBS , 3 MONTHS OF current bank statements showing payroll direct deposit, IRA/Pension/Annuity statements

APPLICATIONS CAN BE SCANNED BACK TO info@raysofrelief.org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