Financial Assistance Request Application

Shine For Scott, Inc. offers financial assistance to patients who have been diagnosed with colon cancer or are in need of a colon cancer screening, and who meet the eligibility requirements of our program.

Financial Assistance Available – ALL CONTINGENT ON *ELIGIBILITY AND FUND AVAILABILITY:

❋ **Screening** - *Patient MUST provide an estimated cost of service from attending physician, or bill of services rendered.*
Assist with cost of necessary screenings for high risk patients, including though not limited to flexible sigmoidoscopy, colonoscopy, barium enema, CT colonography, fecal occult blood test, fecal immunochemical test, and stool DNA test.

❋ **Special Funding** - *Patient MUST provide supporting information/documentation.*
Assist with expenses not covered in any of the specified categories.

❋ **Treatment Co-Pay Assistance** – *Patient MUST provide documentation reflecting Out of Pocket amount.*
Assist with out of pocket expenses during treatment.

❋ **Prescription Drug Assistance** - *Patient MUST provide "Test Script" from pharmacy.*
Assist with prescription costs.

❋ **Rent/Mortgage/Utility Expenses** - *Patient MUST provide past due bill.*
Assist with past due bills.

❋ **Funds to Travel for a Second Opinion** - *Patient MUST provide supporting information/documentation.*
Assist with travel costs.

Proof of **income is required, along with supporting documentation specific to your individual request. Eligibility will not be assessed until all necessary documentation has been received.
**You will need to provide either your most recent W2 or a check stub issued within the past two weeks.

Please contact Shine For Scott, at the email listed below, with any questions or concerns.

Applications may be emailed to: TheBoard@ShineForScott.org
OR
Applications may be sent via the United States Postal Office: P.O. Box 1, Gracewood, GA, 30812

P.O.Box 1, Gracewood, GA 30812

Application For Financial Assistance

Date Of Birth: ______________________________

Applicant's Name: ______________________________ Medical/Disability Insurance: Yes / No

Primary Cancer Diagnosis (if applicable): ______________________________

Residing County: ______________________________

Home Address: ______________________________

Street City State Zip

Phone Number: ______________________________

Email Address: ______________________________

*Annual Gross Household Income: ______________________________

Number of People in Household: ______________________________

Attending Physician's Name: ______________________________

Physician Office Contact Person: ______________________________

Practice Name: ______________________________

Practice Phone Number: ______________________________

Practice Address: ______________________________

Street City State Zip

*Reason for Financial Assistance Request

_____ Screening Cost

_____ Prescription Assistance

_____ Treatment Co-Pay Assistance

_____ Rent/Mortgage/Utility Expenses

_____ Funds to travel for a second opinion

_____ Special Funding - *Please explain request in detail.*

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I attest that all information provided during the request for Financial Assistance application process is accurate and true.

______________________________ ______________________________

Physician/Healthcare Professional Signature Printed Name Date

______________________________ ______________________________

Applicant/Patient Signature Printed Name Date

*Supporting Documentation MUST be submitted before eligibility will be assessed.

Shine For Scott, Inc. 501(c)(3)