

For Office Use Only

Accepted Denied

Date Received: _____

Amount Approved: _____

Check Issued: _____

all medical information will remain confidential and any reports written about the program WILL NOT use my name.

I understand and agree that fulfillment of assistance may result in publicity, whether or not Sisters Network Cincinnati actively seeks to publicize this service.

I understand and recognize that the granting of any assistance and the participation of any person in the project is contingent upon approval by Sisters Network Cincinnati as well as compliance with all conditions, qualifications, and restrictions designated by Sisters Network Cincinnati.

In addition to receiving assistance from SGHH, we request that you support our effort to make this program available to other breast cancer patients by volunteering at our office or at one of our fundraising events.

I also understand that there is a limit to the number of requests for assistance I make and receive, depending upon the type and cost of service being requested and offered.

A Medical Release Form from your healthcare provider verifying your breast cancer treatment status is necessary for consideration of your financial request. I hereby certify that I have been diagnosed with breast cancer and require financial assistance. I also affirm that the above information is true and correct. I understand that the information I have provided is subject to verification by the Sisters Giving Help and Hope Emergency Financial Assistance Committee. Willfully providing false or misleading information may result in denial of current or future requests for direct emergency financial assistance.

Signature of Patient/ Family Member/ Other Date: _____



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CERTIFICATION OF HEALTH CARE PROVIDER

TO BE COMPLETED BY PATIENT: CONSENT: I hereby authorize my physician to release my personal protected medical information to Sisters Network Cincinnati Affiliate Chapter, P.O. Box 371034, Cincinnati, OH 45222 to verify my breast cancer diagnosis and treatment status thereby confirming the validity of this certificate.

(PLEASE PRINT)

Physician Name: _____ Phone Number _____

Type of Practice _____

Address _____

Patient Signature _____

Patient Name _____

Date _____

TO BE COMPLETED BY PHYSICIAN

1. Patient Name: _____

2. Has the patient been diagnosed with breast cancer? Date of Diagnosis _____

3. Stage and Type of Breast Cancer _____

4. Has the patient visited a health care provider two or more times to receive treatment for the current condition? YES NO

If yes, give the probable duration or anticipated schedule of treatments?

(Signature of Health Care Provider)

(Date)

PLEASE FAX TO: 513.541.0637

OR MAIL TO :

Sisters Network Cincinnati ~ P.O. Box 371034 ~ Cincinnati, OH 45222-1034