Application for Rein In Cancer Direct Assistance

Rein in Cancer will provide $500.00 financial assistance to cancer patients (must be currently in treatment).

- **Must be an active member of AQHA, NRHA, NCHA or NRCHA (must provide faxed or scanned copy of current card)**
- **Must provide a faxed copy of current Pathology report from cancer (2016 only)**
- **Copy of driver's license and social security card-address on Driver's License must match mailing address**
- **Must provide completely filled out application including HIPPA release form.**

  Once completed applications are received, funds will be distributed by us mail to recipient within 2 business days. Payment will come in the form of a check made out to patient/applicant.

- **PLEASE NOTE: Incomplete applications will not be processed for payment**

RIC Cares Fund Check list prior to applying

Copy of NRHA, AQHA, NRCHA, or NCHA 2014 current membership card
Copy of Pathology Report showing cancer diagnosis
Completely filled out application
Copy of Driver's License AND Social Security Card (these are required as a 501c3 to keep record of donations)
HIPPA Form completed AND signed.

Mail your completed application to:
Rein In Cancer
13181 US Highway 177
Byars, OK 74831

Or
Fax completed application to:
Fax 580-759-3999 or email to info@reinincancer.com or mail to
Rein In Cancer

PLEASE do not send partially completed applications. Only completed applications will be considered for funding

APPLICATION FOR FINANCIAL ASSISTANCE

Drivers License, current Association Membership card (AQHA, NRCHA, NRHA, NCHA) and Social Security Card must be faxed, mailed or scanned and submitted with this application.

First name: _____ Last name: _____ Today's date_____
Address: _____ City, State, Zip: _____
Phone number: Home ( ) _____ Work ( ) _____
Cell ( )_____ Email Address _____
Date of birth: _____ If patient is a minor (under 18), name of parent or guardian: _____

□ Male □ Female Ethnicity: □ White □ African American □ Latino □ Asian □ Other _____

MEDICAL – Pathology report must be submitted

Date of diagnosis: _____ Primary cancer: _____ Stage _____

□ New diagnosis □ Recurrence **Is patient in active treatment? □ Yes □ No**

Please indicate type of treatment(s) planned or re, received or receiving ***(please check all that apply)***
□ Chemotherapy □ Radiation □ Surgery □Hormonal □ Palliative care □ Bone marrow/stem cell transplant

Health Insurance Y ___ N ____

Please share with us your horse related activities: Showing, trail riding, breeding, training, etc

Please share how these funds and or your horse related associations will help aid in your recovery.

Please be aware that funds are limited and based on availability. Patients must also meet RIC's eligibility requirements

HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164)
(http://www.access.gpo.gov/nara/cfr/waisidx_07/45crf160_07.html)
(http://www.access.gpo.gov/nara/cfr/waisidx_07/45crf164_07.html)

1) AUTHORIZATION
I _____ (print name) Authorize _____
(healthcare provider) to disclose the protected health information described below to Rein In Cancer Cares Fund

2) EFFECTIVE PERIOD
This authorization for release of information covers the period of healthcare from _____
(date) to and through _____ (date).

3) EXTENT OF AUTHORIZATION
I authorize the release of my health record only as it pertains to my cancer diagnosis and treatment.

4) This medical information may be used by Rein In Cancer Cares Fund for the purpose of evaluating my eligibility for financial aid according to their guidelines or for other purposes as I may direct.

5) This authorization shall be in force and effect until ___12-30-2014____ (date or event), at which time this authorization expires.

6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7) I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative:

_____ _____
Signature **Date**

_____
Please Print Name
PF HIPPA Authorization Form 12/1/10