



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 copy of current Pathology report from
- 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.

RIC Cares Fund Check list prior to applying

Copy of NRHA, AQHA, NRCHA, or NCHA 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



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