Fremont County's non-profit assistance fund

Tough Enough to Help *Cancer Fund*

- Tough Enough to Help Cancer Fund is for Fremont County residents who are currently receiving treatment due to **active** cancer.
- Up to $800.00 is available for household expenses and/or travel in a 12 month period.
- Limit of two assistance periods.
- Obtain an application from Help for Health, your medical provider or helpforhealthwy.com
- Complete application.
- **APPLICANT** must sign application, if physically able. **NO** application will be acceptable without applicant's signature. If applicant is not able to do so, medical personnel may indicate why applicant is unable to sign.
- Medical provider statement page completed by a nurse, doctor or other medical staff from a medical facility, which is involved in the treatment of applicant's care.
- Application must be accompanied by proof of residency. This can be a bill, or something proving the client is a Fremont County resident. This fund is only available to Fremont County residents.
- Authorization to release information is **REQUIRED.** A representative from Tough Enough to Help Cancer Fund may contact your medical provider, to verify diagnosis and needed travel. We will not ask for or accept medical records.
- **ASSISTANCE AGREEMENT** is assistance with household **expenses** and **travel** only. We cannot assist with medical bills, medical supplies, prescriptions or PAST expenses incurred.
- **We require receipts returned** showing where monies were spent if a prepaid travel card was issued. If receipts are not returned, then assistance may not be granted in the future.
- **Monies are not paid directly to the applicant.** Monies are paid to the company the bill is owed to.

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REQUEST FOR ASSISTANCE

Please print, and complete the entire form.

Applicant's Name: _____

Physical Address: _____

City: _____ Phone: _____

Are you a resident of Fremont County?* ☐ Yes ☐ No

**Must provide certification of residency such as a utility bill.*

Emergency Contact Information

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Information

Doctor Name: _____ Doctor Phone: _____

Diagnosis: _____

Describe assistance needed and how that assistance will affect you. *(Use the back if more space is needed)*

_____

_____

_____

_____

_____

Signature of Applicant: _____ Date: _____

Signature of Witness: _____ Date: _____

Help for Health · Tough Enough to Help Cancer Fund
716 College View Dr. Suite B · Riverton, WY 82501
307-856-1206 307-856-6056 Fax

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Medical Provider Statement

Your assistance request will not be considered without a professional referral.

Applicant's Name: _____ Date: _____

Please describe the situation of the applicant, and why assistance is needed.

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

Signature of Referring Professional: _____

Referring Agency: _____

Address: _____

_____

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AUTHORIZATION TO RELEASE INFORMATION

This form is used to release your protected health information as required by federal and state laws. Your authorization allows your doctor and hospital to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to your doctor and hospital. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

I *(please print your name)* _____

authorize *(please print doctor's office name & address)*:

_____

_____

To release my protected health information to Help for Health Tough Enough To Help Cancer Fund.

The information to be released consists of the diagnosis, and schedule and course of treatment in order to determine eligibility and the extent of support to be received through the Tough Enough to Help Cancer Fund.

This authorization will expire when I notify both the doctor and hospital listed above that I have revoked it.

By signing below, I authorize the release of my protected health information as described above.

Name: *(please print)* _____

Signature: _____ Date: _____

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ASSISTANCE AGREEMENT

This agreement is set forth by Help for Health Tough Enough to Help Cancer Fund, and is between the parties signed below. The Tough Enough to Help Cancer Fund is able to assist families with regular household bills, travel expenses, and other day-to-day expenditures. We cannot, however, provide relief for incurred medical expenses.

Date:_____

Client or Family Representative: _____

Please Note: Failure to return receipts may result in inability of the fund to offer further assistance. If funds are misused, the Tough Enough to Help Cancer Fund will seek reimbursement legally if necessary.

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