

COACH KILL CANCER FUND
APPLICATION
CONFIDENTIAL



Please fill in as much information as possible. Please print or type:

1. Name of applicant in need of assistance: _____
(Last) (First) (Middle Initial)

2. Address: _____
(Street) (City) (State) (Zip)

Phone: _____ E-mail: _____

3. Birth date: _____/_____/_____ SSN: _____

4. Insurance: Yes No

5. Family Income Information: \$0 - \$20,000 \$20,000 - \$30,000 \$30,000 - \$40,000 \$40,000 - Above

6. Condition being treated for: _____

8. Name & address of physician: _____

9. Please provide specific information about what assistance is being applied for: _____

10. Attach bill(s) relating to reason expressed in #9 or explanation of specific need.

11. Amount requested: \$ _____

12. Check payable to: _____

Release of information – I give permission to SIH/Coach Kill Cancer Fund to disclose, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rules and Regulations, all or any part of my medical record for treatment, payment or health care operations. This permission includes the release of medical information relating to my diagnosis, treatment and/or hospitalization for cancer and other childhood diseases. In addition I allow any health care provider, including any physicians and facilities to which I may be transferred, to provide information to SIH/Coach Kill Cancer Fund upon request, concerning my care, condition, and treatment, for quality improvement, risk management or verification purposes.

Signature of Applicant or Legal Guardian

Date

(Printed name of Applicant or Legal Guardian)

(Over)

Personal Representative Authorization - I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person named below. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Signature of Applicant

Authorized Representative

Place completed application in envelope addressed to Coach Kill Cancer Fund, P.O. Box 3988,
Carbondale, IL 62902 or hand deliver to SIH at 1239 E. Main St., University Mall, Carbondale, IL 62901.

COACH KILL CANCER FUND USE ONLY

Date: _____ Approved: _____ Check #: _____

Disapproved: _____ Reason: _____

Administrative Director of Community Affairs