In order to submit this form, you should open it with Adobe Acrobat Reader.

RACHEL'S HELPING HANDS CANCER

GRANT APPLICATION

HIPAA SUMMARY

WHAT IS THE NOTICE FOR? This notice of Privacy Practices (Notice) describes how Rachel's Helping Hands Cancer Foundation (We or US) may use and disclose your medical information that we maintain and how you can get access to this information.

WHO ARE WE? RACHEL'S HELPING HANDS CANCER FOUNDATION is a non-profit organization which provides monies for cancer patients who cannot afford their deductibles.

WHY DO YOU NEED THIS NOTICE? The Health Insurance Portability and Accountability Act of 1996. as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us with regard to how we may use and disclose your personal health information (PHI). Your PHI includes medical information about you such as your medical records and the care and services that you have received. We are committed to maintaining the privacy of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the minimum amount of data necessary to respond to the need or request unless otherwise permitted by law.

WHEN CAN WE USE/DISCLOSE YOUR PHI? There are certain uses and disclosures of your PHI that we may undertake without your written or other authorization. These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the service we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information without your written or other authorization may include doctors, nurses, health care students, and other hospital staff.

WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET FORTH IN THIS NOTICE. You may revoke this authorization at any time. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information
- Sexually transmitted disease information
- Psychotherapy notes
- Mental health information Drug and alcohol information Genetic information
- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc.)

We will also seek your written authorization for any "marketing" activities we may conduct or where we would receive money for providing a third party with your PHI.

WHAT RIGHTS DO YOU HAVE FOR YOUR PHI? You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL request but may not be required to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at any time.

CAN WE CHANGE THIS NOTICE? We may change this Notice at any time. The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice. You may obtain the new Notice in hard copy as well from our Privacy office.

ADDITIONAL INFORMATION/COMPLAINTS. You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office and file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.

THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE. PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT
FOLLOWS. WE WELCOME ANY QUESTIONS YOU MAY HAVE.

Facility/Physician/Treatment Name *

First Name Last Name

Facility/Physician/Social Worker Email *

example@example.com

Phone *

Fax

Date *

Month Day Year

RACHEL'S HELPING HANDS CANCER GRANT

HIPAA Authorization - Patient

SUMMARY

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Patient Email

example@example.com

Date *

Month Day Year

Confidential Communication List

Communication List

	Name	Phone	Email	Relationship
Primary Contact				
Secondary Contact				
Other				

Date

Month Day Year

Personal Story

Authorization Form

Personal Story:

Tell us more

I hereby authorize RACHEL'S HELPING HANDS CANCER FOUNDATION to share my Personal Story as follows (please check one): *

- ☐ Rachel's Helping Hands can share personal story, including first name, but not last name, including online uses.
- ☐ Rachel's Helping Hands can share personal story, but without use of first or last name, including online uses.
- ☐ Rachel's Helping Hands cannot share personal story

Name of Patient (please type) *

First Name Last Name

Date *

Month Day Year

RACHEL'S HELPING HANDS GRANT APPLICATION

You must be a US Citizen or legal resident to be eligible for assistance. You must be in active chemotherapy or a radiation treatment program to receive assistance. Please call the foundation at 1-866-722-4358 if you have any questions..

Step 1: Patient Information

Patient Name *

First Name Last Name

Todays Date *

Month Day Year

Gender

Phone *

Patient Address: *

Street Address

Street Address Line 2

City | County/State/Province

Postal / Zip Code | Country

Patient Email: *

Email will be utilized for future communication.

Step 2: Prescribing Physician/Facility/Treatment Center

Applications not submitted through social worker, prescribing physician, or facility center will be contacted directly for validation & authorization of information.

Physician's/Facility/Treatment Center *

Name of Facility/Treatment Center: Ex: Einstein Medical

Who are you working with: *

Name of Social Worker, Nurse, Clinician, or member of Oncology Team

Facility/Social Worker/Clinician/Oncology Team's Email *

Please provide an email address for your social worker, nurse, clinician, or Oncology team.

Phone *

Fax

Step 3: Insurance Information

You must have insurance coverage in order to be eligible. Please include a photocopy of your insurance card (front & back) for medical assistance.

Primary Insurance Co. *

Insurance Company Name

Insurance Co. Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Insurance Phone *

Insurance Fax

Member ID: *

Group #:

What type of Insurance Plan is this? Please check all that apply. *

- ☐ Medicare A&B
- ☐ Medicare Advantage
- ☐ Private
- ☐ Cobra
- ☐

Date Cobra insurance ends (if applicable)

Does this plan include prescription coverage? *

Step 4: Income Verification

Income Sources - Yearly Gross Income

	Patient	Spouse	Other
Salary (before taxes)			
Unemployment Income			
Medicare Wages or Social Security Disability			
Retirement Income			
Non Taxable Income			
Interest/Dividends/Rental Income			
Alimony/Child Support			
Net Business or Other Income			
Total			

Asset Sources

	Patient	Spouse	Other
Cash in Banks			
Marketable Securities			
Real Estate Owned (excluding primary residence)			
Other Assets			
Total			

Step 5: Proof of Copayments/Out-of-Pocket Medical Expenses

You must attach proof of co-pay or medical expenses to be considered for reimbursement

Date *

Month Day Year

Date

Month Day Year

Step 6 - Consent

RACHEL'S HELPING HANDS CANCER FOUNDATION

I give The Rachel Paster Helping Hands Cancer Foundation, Inc. permission to:

- Check my information to make sure it is true and complete.
- Share my information with the people helping with the foundation.
- Contact me by email or phone about the Foundation.

I promise that:

- All the information in this application, including all copies of documents providing my income, is true and complete.
- I am authorized to sign this application.
- I will contact the Foundation if any of the information about my prescription drug coverage, insurance status, pharmacy/infusion provider changes and/or my employment or salary changes.
- I do not receive any other financial assistance for the expenses that I have asked the Foundation to cover. This includes Medicaid, state drug assistance programs, and medical flexible spending accounts.
- I am not receiving other financial assistance from other co-payment assistance programs for the same medical expenses and/or co-pays.

I understand that the Foundation will only use my information to:

- Decide if I qualify to participate in the Foundation's medical or co-pay assistance program.
- Administer or improve the Foundation

I understand that I can call 866-722-4358 at anytime to:

- Withdraw from the Foundation.
- Cancel my permission to use my information and withdraw from the program

I understand that:

- The Foundation can ask for more information from me at any time.·The Foundation permission to contact the person named below with follow-up questions about my application (this applies only if someone completed this application for you)

Please fill out Rachel's Helping Hands HIPAA & Grant Application in its entirity.

You can:

- Fill HIPAA & Grant Application Online & Submit
- Save your progress as you go & print to PDF
- Prefer to mail the HIPAA & Grant Application? Please Print Form (above), fill out, & mail to: Rachel's Helping Hands Cancer Foundation, PO Box 217 Langhorne, PA 19047
- Prefer to fax the HIPAA & Grant Application? Please fax to: 877-711-5629

Date *

Month Day Year

Thank you for considering Rachel's Helping Hands Cancer Foundation. After you submit your HIPAA &

Grant Application, a member of our team will contact the physician or facility with next steps. If we require any additional information, we will also notify of what may or may not be missing.

If you do not want to submit online, you can:

- Save your progress as you go & print to PDF
- Please Print Form (above), fill out, & mail to: Rachel's Helping Hands Cancer Foundation, PO Box 217 Langhorne, PA 19047
- Prefer to fax the HIPAA & Grant Application? Please fax to: 877-711-5629