Women Involved in Nurturing, Giving, Sharing, Inc.

APPLICATION CHECK LIST

Full application includes

- Patient Information Form.
- Household & Family Financial Profiles "**Patients must be 200% below poverty level**"
- Employment/Salary Verification. This form must be signed by the employer.
- Methodist Healthcare System Financial Assistance Application. Complete all areas and send the specific documents requested.
- Acknowledgement of Privacy Practices.
- Medical Release Form.

Financial Documentation required /must submit 1 of 8

- Most Recent IRS Tax Return.
- Most recent pay stub (if applicable).
- Notarized letter stating your means of financial support.
- Employment Verification letter.
- Copy of recent Utility Bill.
- Copy of Photo ID, Social Security Card or proof of TIN.
- COBRA Election form (if applicable).

We also require that you furnish the following medical records

- All pathology reports relating to your diagnosis of breast cancer.
- All reports from mammogram, ultrasound or other screening procedure.
- Physician notes and dictation relating to the diagnosis and/or treatment of breast cancer. We also require that you apply for Medicaid benefits and provide your letter of denial to us within 60 days. If you applied to Medicaid within the past 3 months, please send a copy of your determination letter along with your packet.

Original forms must be mailed back to WINGS. No fax or electronic copies will be accepted.

WINGS
PO Box 5007
San Antonio Texas 78201

After we receive your ***complete*** application package, it will take approximately one week to review and process your application.

If you have any question while competing Application please call office 210-946-9464

If approved, you will be sent a letter stating you have been approved and for what program. New patients will receive an ID card that you must present to all participating providers.

PATIENT INFORMATION FORM

PLEASE PRINT

Last: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security or TIN #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

County: _____ E-mail: _____

CHECK ALL THAT APPLY TO YOU

Marital Status: Single _____ Married _____ Divorced _____ Widowed ____Separated ____

Single-parent Household _____Two-parent Household_____ Head of Household_____

Ethnicity: African American_____ Anglo _____ Hispanic _____ Native American _____

Other Primary Language: English: _____ Spanish: _____ Both: _____ Other: _____

Number of Children: _____

Communication Authorization

(Please Complete)

We are committed to providing private and efficient communication with you.

Please indicate the preferred method of contact: telephone or email.

Should we need to reach you by phone, please provide appropriate telephone number (s) we can share info with.

Name: _____ Email: _____

Phone: _____

Emergency Contact: Name/Relationship

Phone: _____ Email: _____

Women Involved in Nurturing, Giving, Sharing, Inc.

BREAST CANCER QUESTIONNAIRE

Do you have medical insurance? Yes _____ No____ If yes, Policy # _____
Carrier Phone #: _____ Effective Date: _____
PLEASE INCLUDE A COPY OF YOUR INSURANCE POLICY WITH THIS APPLICATION.

Copy of all Pathology, Mammogram, Ultrasound or other screening procedures

Are you eligible for Medicaid? Yes___ No____ Don't know _____
If you have been denied for Medicaid, please state reason for denial _____

_____

BREAST CANCER STAGE: _____ Date of diagnosis: _____

Have you had breast cancer surgery? Yes_____ No____ Date of surgery_____

Have you ever received Chemotherapy? Yes____ No____ Date of 1st Treatment _____

Please indicate the date of your most recent chemotherapy treatment_____
Have you completed all of your prescribed chemotherapy? Yes ____ No _____
Have you ever received Radiation Therapy? Yes____ No_____ Please indicate the date of your most recent radiation treatment: _____

- How did you hear about WINGS:_____

HOUSEHOLD PROFILE

Name	Relationship	Date of Birth	Social Security	Code

EMPLOYMENT CODE: Current employment state of each household member

A = Employed Full Time **B** = Employed Part Time **C** = Unemployed/Able to Work
D = Unemployed/Retired **E** = Unemployed/Disabled **F** = Student **G** = Other FAMILY

FINANCIAL PROFILE Include information for all adults including age 18 who are living at home and are employed.

MONTHLY INCOME		MONTHLY EXPENSES	
Salary/Wages	**$**	**Rent/Mortgage**	**$**
AFDC/Food Stamp	**$**	**Electric, Gas, Water, Phone**	**$**
Social Security	**$**	**Food**	**$**
SSI	**$**	**Car Payment**	**$**
VA	**$**	**Gasoline**	**$**
Investment Income	**$**	**Car Insurance**	**$**
Rental Property Income	**$**	**Life Insurance**	**$**
Other	**$**	**Health Insurance**	**$**
Other	**$**	**Other**	**$**
TOTAL	**$**	**TOTAL**	**$**

Please provide any other information regarding your income, expenses or assets that you would like for us to know._____

_____

I certify that the information I have provided is true and complete. By signing below I also agree that I will notify WINGS if I become covered by insurance (including Medicaid or Medicare), or if there is a significant change in my household income. I understand the information I submit concerning my annual income and family size is subject to verification by WINGS. I also understand that if the information I presented in this document determined to be false, such determination will result in a denial of my application and I will be liable for all charges on any services provided.

Name: _____ DATE: _____

Women Involved in Nurturing, Giving, Sharing, Inc.

RELEASE OF MEDICAL INFORMATION AND DISCLOSURE

I hereby request that_____ send copies of my medical information to:

WINGS (Women Involved in Nurturing, Giving, Sharing Inc.)

PO Box 5007
San Antonio, TX 78201
Fax: 210-634-1255

- I hereby request that provide me copies of the information below. I will deliver the information to WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) and I will be responsible for the privacy of the copies.

- Information requested:

- I authorize WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) to provide my personal, financial or any other information as needed for the processing of my enrollment in designated Pharmacy Assistance Programs to my prescribing physicians.

- I authorize WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) to use my personal, financial or any other information necessary for my enrollment in designated Pharmacy Assistance Programs.

- I have been given the opportunity to ask questions about the services and all of my questions have been answered to my satisfaction. I have received a copy of the WINGS privacy notification dated September 2, 2003.

Patient's Name _____

Patient's or Legal Guardian's Signature _____ Date _____

Please return a signed Release of Medical Information and Disclosure form in the WINGS envelope provided and keep a copy for your records.

This form is to be filed in the permanent patient record at WINGS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical and financial information about you can be used and disclosed and how you can get access to this information. **Please read it carefully**.

This "Notice of Privacy Practices" is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information.

You will be asked to acknowledge receipt of this notice. Our intent is to make you aware of the disclosures of your protected health information and privacy rights. If you decline to sign the acknowledgement, we will continue to provide services, however, we will disclose your protected health information when authorized by law.

Our Duty: We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this notice, however, we reserve the right to change this notice. This notice will be effective on September 2, 2003, and applies to health information we already have about you, as well as any information we receive in the future. You may obtain a "Notice of Privacy Practices" from Women Involved in Nurturing, Giving, Sharing Inc. (WINGS) **PO Box 5007, San Antonio, Texas 78201** or from the WINGS **website, www.texaswings.org.**

Your Rights: You may exercise the following rights by submitting a written request to the WINGS Privacy Officer. The WINGS Privacy Officer is Kim Hinze, Executive Director.

Right to Inspect and Copy: You may inspect and obtain a copy of your protected health information that is in your medical record for as long as we maintain the record. Be aware that there is an established fee for making copies of your medical record. This right does not include inspection and copying information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and when access to protected health information is prohibited by law.

Right to Request Restrictions: You may ask us not to disclose any part of your protected health information. Requests should be noted on the "Authorization for Release of Medical Information."

Right to Request Confidential Communications: You may request that we communicate with you using an alternative means. We will accommodate your request, if possible.

Right to Request Amendment: If you believe the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain the information.

Right to Account Disclosures: You may request, in writing, a list of the disclosures we have made in your protected health information. The disclosures must have been made after September 2, 2003, and no more than six (6) years prior to the date of request. This right applies to disclosures other than those listed on the next page. Other uses and disclosures will be made only with your written authorization and you make revoke this authorization, in writing, at any time.

• We may use and disclose your protected health information to coordinate or manage your treatment/services. This includes hospitals, clinics, physicians, other health care providers/clinicians, pharmacy assistance programs, which may become involved in your care or services you receive.

• We may use and disclose your protected health information to obtain payment for your treatment/services. This includes activities WINGS performs prior to coordinating care, such as determining eligibility or coverage for benefits and reviewing services provided for your medical necessity. An example is determining eligibility for WINGS services.

• We may use or disclose your protected health information to coordinate activities for other health care-related activities. For example, we may contact you to provide information about treatment alternatives or other health-related benefit services that may be of interest to you.

• We may use or disclose your protected health information to your family involved in your care or for emergency notification.

Right to Obtain a Copy of this Notice: You may obtain a "Notice of Privacy Practices" from Women Involved in Nurturing, Giving, Sharing Inc. (WINGS) PO Box 5007, San Antonio, Texas 78201 or from the WINGS website, www.texaswings.org.

Received Release of Medical Information and Disclosure by WINGS

On_____ by _____

Complaints: If you believe your privacy rights have been violated, you may submit a written complaint to the WINGS Privacy Officer. No retaliation will occur against you for filing a complaint.

Submit questions or comments to our Privacy Officer:

Kim Hinze, Executive Director
WINGS, PO Box 5007
San Antonio, Texas 78201
210-946-9464 (fax) 210-634-1255

ACKNOWLEDGEMENT
RECEIPT OF PRIVACY PRACTICES
WINGS

By signing below, I acknowledge that I have received the Notice of Privacy Practices from WINGS, (Women Involved in Nurturing, Giving & Sharing).

Printed Name: _____

Signature: _____

Date: _____