PATIENT APPLICATION CHECKLIST

Please check off the documents named below. These documents are all required in this application.

Date: (MM/DD/YYYY): ______________________________________

Formal Name: ________________________________ (as it appears on you Identification card or taxes)

- ○ Copy of Photo ID: __________ Received
- ○ Copy of Social Security/Texas Identification Number: __________ Received
- ○ Breast Cancer Questionnaire: __________ Received
- ○ Patient Profile: __________ Received
- ○ Household Profile Form: __________ Received
- ○ Notice of Privacy Practice Form: __________ Received
- ○ Medical Release Form: __________ Received
- ○ Methodist Health System Financial Assistant Application: _________ Received
- ○ Income Document _________ Received
- ○ Breast and Cervical Medicaid Denial Letter: __________ Received
- ○ Copy of Any Utility Bill: __________ Received
- ○ Patient Testimonial/Photo Consent Form: __________ Received
- ○ Adult Well-Being Assessment: __________ Received
- ○ Drs. Notes: __________ Received

After we receive your ***COMPLETE*** application package, it will take approximately 10 business days to review and process your application.

If you have any questions while completing this Application please call our office at 210-946-9464.

PATIENT PROFILE

PLEASE PRINT

Application Date (MM/DD/YYYY): ___________________

Last: _____________________________ First Name: ______________________________ MI: ___________

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

Address: ____

____

City: ________________________ State: ____________________ County: ____________ Zip: ________

Home Phone: (   ) ______________________ Work Phone: (   ) _____________________________

Cell Phone: (   ) ___________________________ E-mail: ___________________________________

County Precinct: ________________________ City District:____________________

CHECK ALL THAT APPLY TO YOU

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

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

Number of Children: __________________

Ethnicity: African American:_____ White not Hispanic: _____ Hispanic: ____ Other: _____

Communication Authorization (Please Complete):

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

Please check the preferred method of contact: Telephone:_____ or Email:_____.

Please provide two names of local friends or relatives not living in same address (2) appropriate telephone number(s). Emergency Contact Name relationship to patient:

(1)Name: ___________________________ Relationship to patient: _______________

Address: ____

____

City: ______________________ State: ________ County: ______________ Zip: _______

Emergency Contact Phone: ( ) _______________________

Emergency Contact E-mail: ________________________________

Cell Phone: ( ) _________________________

(2)Name: ___________________________ Relationship to patient: ________________

Address: ____

____

City: ___________________ County: ________________ State: ________ Zip: ________

Emergency Contact Phone: ( ) _______________________

Emergency Contact E-mail: ________________________________

Cell Phone ( ) _________________________

EMPLOYER

Employer Name: ____

Address: ____

____

City: _______________________ County: ___________________ State: _________ Zip: _____

Employer Phone Number: _________________ ext. ______________

Employer Fax Number: ___________________ ext. _______________

Email Address: ____

BREAST CANCER QUESTIONNAIRE

Do you have medical insurance? Yes: _______ No: ______ If yes, Policy # ________________________
Carrier Phone #: ____________ Provider: ____
Effective Date: ________________

PLEASE INCLUDE A COPY OF YOUR INSURANCE POLICY WITH THIS APPLICATION

Copy all Pathology, Mammogram, Ultrasound, or other screening procedures **required.**

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 your prescribed chemotherapy? Yes: ____ No: _____

Have you ever received Radiation Therapy? Yes: ____ No: _____
Please indicate the date of your most recent radiation treatment: __________________________

Please provide updated photo of patient and story:
____

How did you hear about WINGS? ____

ACKNOWLEDGEMENT RECIEPT OF PRIVACY PRACTICES

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

Release of Survey Information for Grants/ Funding etc.

Printed Name: _______________________________________

Signature: ____

Date: ____

HOUSEHOLD PROFILE

Date of Household Profile Registration (MM/DD/YYYY): ______________________________

Single-parent Household: ____ Two-parent Household: _____ Head of Household: _______

Household Address: ___________________________

City: _______________________ County: ___________________ State: _________ Zip: _____

Household Home Phone: ______________________ ext. ___________________

Number of Adults in Household: ___________________

Number of Children in Household: __________________

Total Number of Household Members: ______________

EMPLOYMENT CODE: Current employment status 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

Name	Relationship	Date of Birth	Code

INCOME:

Signature: _______________________________Date: ____

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	$	Electricity	$
Food Stamps	$	Gas	$
Social Security Benefits	$	Water	$
SSI	$	Phone	$
VA Benefits	$	Food	$
Investment Income	$	Car Payment	$
Rental Property Income	$	Gasoline	$
Other	$	Car Insurance	$
Other	$	Life Insurance	$
Other	$	Health Insurance	$
Other	$	Other Expenses	$
TOTAL	$	TOTAL	$

TOTAL GROSS MONTHLY INCOME: ___________________________

TOTAL MONTHLY EXPENSES: ________________________________

TOTAL NET MONTHLY INCOME: ______________________________

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.

Signature: _________________________________Date: ____

RELEASE OF MEDICAL INFORMATION AND DISCLOSURE

I hereby request that_________________________ send copies of my medical information to: Women Involved in Nurturing, Giving, Sharing, Inc. (WINGS).

WINGS
2929 Mossrock Ste. 205
San Antonio, TX 78230
Phone: 210 946-9464
Fax: 210 634-1255

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

- Information requested:

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

Patient's Name: _______________________________________

Patients 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 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) 2929 Mossrock Ste. 205, San Antonio, Texas 78230 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.

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 (date of WINGS incorporation), 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 with 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) 2929 Mossrock Ste. 205, San Antonio, Texas 78230 or from the WINGS website, www.texaswings.org.

Patient: ________________________________ Date: _____________________________________

PLEASE KEEP FOR YOUR RECORDS

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:

WINGS
2929 Mossrock Ste. 205
San Antonio, TX 78230
Phone: 210 946-9464
Fax: 210 634-125

PATIENT TESTIMONIAL/PHOTO CONSENT FORM

I, ____________________________ grant permission and give my consent to Women Involved in Nurturing, Giving, Sharing (WINGS) to use my testimonial and /or photograph in any and all marketing materials the organization utilizes, including but not limited to print publications, multimedia presentations, on websites, social media and/or in any distribution media. I hereby waive the right to inspect or approve the finished product, including any written copy, wherein my testimonial/photos appear.

I waive the right to royalties or other compensation arising from or related to use of my testimonial and my photographs.

I understand that with my authorization the testimonial/photograph(s) by signing below, I hereby ACKNOWLEDGE AND AGREE THAT I HAVE READ AND UNDERSTAND THE ABOVE.

Signature ___________________________ Date ___________________

RIGHT TO REVOKE

I hereby acknowledge that I have the right to revoke this Release at any time by giving WINGS 30 days written notice of my revocation and submitting it to the contact Privacy Officer.

WINGS
2929 Mossrock Ste. 205
San Antonio, TX 78230
Phone: 210 946-9464
Fax: 210 634-1255

Methodist Healthcare System Financial Assistance Application

Patient Name | Patient Account Number

Telephone Number | Social Security Number | Birth Date (Month/Day/Year)

ü Employed
unemployed

Employer (Name, Address and Telephone Number)

Spouse Name | Social! Security Number | Birth Date {Month/Day/Year)

Patient's Father (If patient is a minor) | Social Security Number | Birth Date (Mond1/Day/Year)

Patient's Mother (If patient is a (minor) | Social Security Number | Birth Date (Month/Day/Year)

A. Wages: Please provide the wages for each of the following persons in your household.

Circle One

Patient $________ Hr/ Wk/ Month/ Year

Patient's Father (if patient is a minor) $________ Circle One Hr/ Wk/ Month/ Year

Spouse $________ Hr/ Wk/ Month/

Patient's Mother (if patient is a minor) $________ Hr/ Wk/ Month/ Year

B . Other Resources: Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, etc. S __________

Please provide the amount of year(y income you receive from these other resources, including interest income, dividends, rental income, etc. S________

C. Family "Members: Please provide the number of persons in the patient's household.

D. Income Verification t ion: Please provide any of the following types of documentation to verify your income.

IRS Form W-2 Employer Verification
Paycheck Remittance Proof of Participation in Governmental Assistance programs such as food stamps, CDIC,
Tax Return Medicaid or AFDC
Bank Statements Social Security or Unemployment Compensation Determination Letters Other, Please Describe
(f you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available

____

! understand Methodist Healthcare System (RNS) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with MHS' evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize MHS to request reports from credit reporting agencies and the Social Security Administration- certify that this information fs true to the best of my knowledge and am aware that falsification of information on this Application may result in denial of financial assistance.

________________________ Date__________

Signature of Patient or Responsible Party

Date

________________________ __________

MHS Employee Signature if any part of Financial
Assistance Application Completed by an MHS Employee

ENG 8/10/2023 YG