F&CT

Financial Assistance for Cancer Treatment
P.O. Box 624 • Tiffin, OH 44883
419-937-2540

Client Application Form

Please complete this form, **sign and date it.** Return it along with your **completed, signed and dated** Physician Authorization Form to F.A.C.T. at the above address.

Name: ______________________________ Social Security #: ____________
Address: ______________________________ Sex: M or F
City, State, Zip: ______________________ Date of Birth: ________________
Telephone: ___________________________ E-Mail: _____________________
Cellphone: ___________________________

Next of Kin: (contact person): ____
Address: ____
City, State, Zip: ______________________ Telephone: ___________________

Physician: ____
Address: ____
City, State, Zip: ______________________ Telephone: ___________________

Diagnosis: ____

Informed Consent

All information on this form is strictly confidential and will be treated as such by F.A.C.T. I authorize F.A.C.T. to discuss my care and treatment related to payment of claims to verify such claims submitted are cancer related. I have reviewed and understand The Services and Rehabilitation Policy of F.A.C.T. of which a copy has been provided to me.

Signature: ________________________________ Date: __________________

Serving Seneca County, Ohio Cancer Patients