Financial Assistance for Cancer Treatment
PO Box 624, Tiffin, OH 44883
Phone: 419.937.2540
Email: factsenecacounty@yahoo.com

# Client Application Form

Please complete this form, **sign and date it.** Return it along with your **completed, signed and dated** Physician Authorization Form and copy of your driver's license to F.A.C.T. at the above address.

**Name:** _____
Address: _____ Sex: M or F
City, State, Zip: _____ Date of Birth: _____
Previous address if less than 2 years:_____
_____
Telephone: _____ E-Mail:_____
Cellphone:_____

**Please provide a copy of your driver's license or state issued ID**. Proof of residency may be required: (utility bill or bank statement)

**Authorized 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***

**Due to board policy, we cannot make reimbursement for any receipt or transportation that is 6 months or older.**