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

Client Application Form

If you have been diagnosed with cancer and are experiencing financial hardship, 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 FACT at the above address.

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

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 FACT. I authorize FACT 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 FACT of which a copy has been provided to me.

Signature: _____ Date:_____

***Serving cancer patients living in Seneca County, Ohio and Wood County, Ohio with a 44830 zip code. ***

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