MAIDEN FLIGHT
Survivors Support Network

PATIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

Person/Organization Providing the Information (Doctor's Office) *[45 C.F.R.§ 164.508(c)(ii) & Civ. Code § 56.11(c)]*	**Person/Organization to Receive the Information** *[45 C.F.R.§ 164.508(c)(iii) & Civ. Code § 56.11(f)]*
Doctor's Name Ph:	Robbie Thomas Founder/President Maiden Flight Cancer Survivor Support Network
Dr.'s / P.A. Signature Date	
Applicant's Signature Date	

Description of the Information to be Released *[45 C.F.R. § 164.508(c)(i)& Civ. Code § 56.11(d) & (g)]*
Telephonic conference and/or faxed documents between Maiden Flight Foundation and the above listed patient and doctor's office regarding patient's medical diagnosis, current treatment and history.
Description of Each Purpose for the Use or Release of the Information *[45 C.F.R. § 164.508(c)(iv)]*
This information will be used for the sole purpose of evaluating the above named patient for support services offered from the Maiden Flight Foundation. This HIPPA release is valid only if signed by both the patient and medical doctor's office and for a 180 day period from the applicant's signature date shown above.

Patient Information **PRINT CLEARLY OR TYPE**

Date of Birth ____________ **Age** _____ **SS#** ____________________ **Home Phone** ____________________

Are you currently working? ☐ **YES** ☐ **NO date last worked** __________ ☑ **Please Check One**

Present employer ______________________________ **address** ______________________________________

Telephone __________________________ **Date of hire** ______________ **Race** _______________

Marital Status: **married** _____ **single** _____ **divorced** _____ **widowed** _____ **Sex: M** ____ **F** _____

Name of children & ages ____

Parent Information if applying for a child and last name, address, Apt # & phone number are different

____

Name of Spouse __________________________ **Employer** ______________________ **hours working** _____

Is spouse working? Y/ N If (N) please explain ____

Assistance Applications (Place an "A" next to those Accepted, a "P" next to those in Process, and a "D" next to those Denied) If denied please explain on a separate sheet so we can better help. Thank you.

Medi-cal ________________ State Disability ______ Social Security _______

State Unemployment _____ Food Stamps ________ Medicare ______________

AFDC ___________________ Bankruptcy _________ Other __________________

Financial Information

FULL DISCLOSURE IS IMPERATIVE FOR YOUR APPLICATION TO BE CONSIDERED

MONTHLY EXPENSES
Monthly Rent ____________________
Landlord Name _____________________
Landlord Phone _____________________
Monthly Mortgage___________________

MONTHLY UTILITIES
Gas __________________
Electric __________________
Water __________________
Phone ____________________
Food ____________________
Auto: year __________ make _________
Mo. payment _________ gas __________

MONTHLY INSURANCE
Health-Name of Ins. Co_________________
Monthly Premium ____________________
Auto Insurance ____________________
Monthly Premium ____________________
How Often Paid ____________________
Are you a Veteran ____________________

MONTHLY INCOME
Self-Name of Employer __________________
Address of Employer _________________
Monthly Salary _________________
Spouse-Name of Employer _________________
Address of Employer __________________
Monthly Salary __________________
Children __________________
Child Support* __________________
Alimony* __________________
State Disability __________________
Social Security (over 65) __________________
Social Security Disability __________________
Supplemental Income (SSI) __________________
Retirement __________________
Investments __________________
Unemployment __________________
Other __________________

CREDIT CARD DEBT
1. ___________________ /mo. __________
Total outstanding: __________ Int. Rate ______
2. ___________________ / mo. ________
Total outstanding: _________ Int. Rate ______
3. ___________________ / mo. ________
Total outstanding: _________ Int. Rate ______

Assets:
Bank/Credit Union checking
Accounts and Balances:
____
____
Savings Accounts
____

MONTHLY MEDICAL
Medications: _____________________________
Co-Payments: _____________________________
Doctors: _____________________________
Not covered by Insurance ____________________
Other monthly expenses: ____________________

IRA or 401K:
____
____

Life Insurance:
____

Other outstanding medical bills: ____

*If you are divorced and not receiving child support or alimony, please explain:

Medical Insurance Carrier ______________________ **Telephone** ______________________

Address ____________________________________ **Group #** __________________

Type of Plan: HMO ________ **PPO** _________ **indemnity** ______

Patient's relation to insured: self ______ **spouse** ______ **parent** ______ **child** _______

Medical Diagnosis _______________________________________ **Date of diagnosis** __________

Current treatment

____

What is your religious preference? ___________________________________

Identify all persons assisting with patient's needs: (include neighbors, friends, relatives, and community organizations)

Person	How they help	How often they help

What is your specific request of the Foundation?

____

____

____

Who referred you to the Maiden Flight Foundation?

Name ________________________ **Address** ____________________ **Telephone** ______________

For administrative purposes, organizations involved with your case may be called to verify your responses to this financial request form. When you sign this form you are acknowledging and agreeing to the above stipulations.

Signature ___________________________________ **Date** ____________________

Foundation Office Use Only	MSW, LCSW Reviewer Use Only
☐ hippa signed & dated, phone number(s) x 2	
☐ county ✓	___________ Date review was Opened / initial Call
IPA Phone Consultation (date/time) set for ________________________	______________________________________
☐ Interpreter Needed ✓ Language ____________	______________________________________
__________ Date IPA faxed to IPA Coordinator	______________________________________
☐ final determination letter sent _____________	______________ Date review was emailed / closed