MY BREAST FRIENDS 941 PATIENT VERIFICATION FORM

My Breast Friends 941 Corporation (MBF 941) is a nonprofit organization that offers personalized support to local clients with breast and other gynecological cancers through programs which provide **FREE** direct services for those in treatment to help with life needs such as house cleaning, meals, baby sitting and transportation to treatment. In order to be eligible for these services, please provide the following information. We look forward to serving local lives.

**Geographical limitations may apply.*

CONTACT INFORMATION

Name: _____

Complete Address: _____

_____

Phone Number: (h) _____ (c) _____

Email: _____

DEMOGRAPHIC INFORMATION

Cancer does not discriminate and neither does MBF941. Eligibility for MBF941 services is **NOT** income based. However, we must report aggregated demographic information for various reasons including grant reporting for various funding vehicles. This aggregated information does not include any of your personally identifiable information. Your answers to these questions will not impact your eligibility for services in any way. Thank you so much for your cooperation!

Birthdate (mm/dd/yyyy):_____/_____/_____

Annual Household income: $_____

Ethnicity (Please select one):

- o Caucasian
- o Black or African American
- o Hispanic
- o Asian/Pacific Islander
- o Multiracial
- o Other _____

Insurance Status (Please select one):

- o Insured
- o Uninsured

Employment Status (Please select one):

- Employed
- Unemployed Before Diagnosis
- Unemployed After Diagnosis

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In order to be eligible for our program, **PLEASE HAVE YOUR PHYSICIAN'S OFFICE OR CASE MANAGER COMPLETE THIS PAGE.**

BRIEF DESCRIPTION OF DIAGNOSIS

Type of Cancer: _____

Stage: _____

CURRENT TREATMENT

- **Radiation**
  - Physician: _____
  - Treatment Facility: _____
- **Chemotherapy**
  - Physician: _____
  - Treatment Facility: _____
- **Surgery**
  - Physician: _____
  - Treatment Facility: _____

I certify that the above patient is receiving cancer treatment under my care.

_____

Physician/Clinical Staff Name – Please Print

_____

Physician/Clinical Staff Signature

_____

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I, _____, hereby authorize my physician, health care professional, mental health care professional dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, and insurance company and the Medical Information Bureau, Inc. or other healthcare clearinghouse that has provided treatment or services, to give, disclose, and release to My Breast Friends 941 Corporation without restrictions, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health conditions. The authority given My Breast Friends 941 Corporation shall supersede any prior agreement that I may have made with my healthcare provider to restrict access to or disclosure of my individually identifiable health information. The authority given to My Breast Friends 941 Corporation, has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider or in the event I am not longer receiving services from My Breast Friends 941 Corporation. This release applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 CFT 160-164.

Participant/Patient Signature

Date (mm/dd/yyyy) _____/_____/_____

By signing and submitting this form, you represent and warrant that all of the information contained in this form is true and accurate to the best of your knowledge and belief. Failure to provide accurate information may result in the termination of any services provided, at the discretion of My Breast Friends 941 Corporation.

By signing and submitting this form, you further acknowledge and agree the My Breast Friends 941 Corporation, has not guaranteed you any particular type or quantity of service. My Breast Friends 941 Corporation provides for the funding and the coordination of services for you. It does not however, warrant or guarantee the nature of the services being provided. You acknowledge and understand the My Breast Friends 941 Corporation, is in no way liable or responsible for any negligence, misconduct, or any other cause of action that you may have related to the companies, corporations, partnerships, organizations, or persons providing services to you as part of the program.

Participant/Patient Signature

Date (mm/dd/yyyy) _____/_____/_____

Thank you for your cooperation. Please submit all pages by email to mybreastfriends941@gmail.com or by U.S. mail to P.O. Box 14122 Bradenton, Florida 34280-4122. Someone will be in contact with you within 5 business days of receiving this application in our office. Please visit our website at mybreastfriends941.org or call 941-807-3357 for more information.

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