PATIENT ASSISTANCE CHECKLIST FOR UNINSURED PATIENTS

❑ I have received the chemotherapy order written by the physician?

❑ I have met with the patient to assess his or her ability to pay for treatment?

❑ Based on this meeting, is the patient able to pay out-of-pocket for drug(s)?

❑ YES ❑NO

If no, list drug(s) below and continue on with checklist.

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❑ Is a replacement drug program available?

❑ YES ❑ NO

If yes, identify drug and program:

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❑ Does the patient qualify for this program?

❑ YES ❑NO

If no, state reason(s) why:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑If yes, I have completed all the necessary forms and paperwork for the drug replacement program.

❑ YES ❑NO

If no, state reasons why:

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❑Does the patient need drug(s) that are not available through a drug replacement program?

❑YES ❑NO

If yes, identify which drugs:

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❑ Is Foundation funding assistance available for any of these drug(s)?

❑YES ❑NO

If yes, identify Foundation(s) and drug(s):

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❑ I have completed all the necessary forms and paperwork for these Foundation funding program(s).

❑YES ❑NO

If no, state reasons why:

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❑Does the patient qualify for charity care within from my clinic, cancer center, hospital, or healthcare system?

❑YES ❑NO

If yes, identify program:

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❑I have completed all the forms and paperwork necessary to apply for this charity care.

❑YES ❑NO

If no, state reasons why:

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❑ Is there a balance or money owed related to treatment?

❑YES ❑NO

If yes, identify balance:

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❑ If yes, I have worked with the patient and family to create a payment plan for the balance of his or her treatment costs.

❑YES ❑NO

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