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.

________________________________________________________

☐ Is a replacement drug program available?
   ☐ YES ☐ NO

If yes, identify drug and program:

________________________________________________________

☐ 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:

________________________________________________________

☐ Does the patient need drug(s) that are not available through a drug replacement program?
   ☐ YES ☐ NO

If yes, identify which drugs:

________________________________________________________

☐ Is Foundation funding assistance available for any of these drug(s)?
   ☐ YES ☐ NO

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

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

Yes  No

If no, state reasons why:

______________________________________________________________________________

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

Yes  No

If yes, identify program:

______________________________________________________________________________

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

Yes  No

If no, state reasons why:

______________________________________________________________________________

Is there a balance or money owed related to treatment?

Yes  No

If yes, identify balance:

______________________________________________________________________________

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