Gritman | LIGHT A CANDLE

# INITIAL REQUEST FORM

*All request forms valid for 6 months from date of initial request or completion of active treatment*

## Program Guidelines:

To qualify under the program guidelines the patient:

1. Must be under active treatment for cancer.

**AND** meet one of the following criteria to be considered a recipient for this program.

2. Patient is uninsured.
3. The patient is within the Charity Care guidelines as established by Gritman Medical Center.
4. The patient is currently unemployed or taking a leave of absence from work due to treatment.
5. The patient's household income has been reduced due to diagnosis and resulting medical treatment.
6. Other circumstances as needed for consideration. This can include but is not limited to purchases of "get well" or celebration of end of treatment gifts such as cakes, flowers, or cards.

If you have any questions or concerns, please do not hesitate to contact us!

Mason Molyneaux, Development Program Assistant

**(208) 883-6231**

Gritman Foundation

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SECTION 1: PATIENT INFORMATION:_____LAC NUMBER:_____

Patient Name:_____

Address_____ City:_____

State:_____ ZIP Code: _____County:_____

Is the patient 18 years or older?_____Y_____N If no, patient guardian name?_____

Phone:_____Email:_____Good time to contact:___Day____Even___Wknd

DOB:_____ GENDER: ____F_____M Patient Diagnosis_____

Date of Diagnosis_____Stage of Cancer_____Is patient undergoing active treatment?__Y__N

Please check services requested: _____gas card_____grocery assistance_____housekeeping_____massage

(OR) - Please provide description of requested service(s) needed:_____

Initial request (*other than certified representative*) made by:_____

As the initial requestor, please have patient sign request to give his or her consent to provide information as required for application:

**Patient Signature**:_____Date:_____

**(Unsigned applications will not be accepted)**

SECTION 2: CERTIFIED REPRESENTATIVE INFORMATION:_____

Physician Name:_____Physician Telephone:_____

Representative Name:_____Title:_____

Representative's Hospital or Clinic Name:_____

Telephone:_____Email:_____Fax:_____

*Applications are only accepted through a certified representative. A certified representative is defined as the patient's doctor, nurse, case manager, or social worker. All sections of this form must be truthfully completed. Any false, incomplete or misleading information will result in an automatic denial. Consideration shall be determined based on all factors as noted in this application and in accordance with the Light A Candle Program policy.

*By signing this application, I attest and agree to the following:

(a) I am the representative listed above, and I am authorized to submit this application on behalf of the patient and the family.
(b) The patient or patient's guardian has given his or her consent to provide the information in this application.
(c) The information provided in this application is truthful and accurate to the best of my knowledge.
(d) I hereby give LACP my consent to use my information and contact me to discuss the request in this application and any related materials if needed.
(e) I verify that the patient meets criteria: 1) Patient is under active treatment for cancer 2) Demonstrates a financial need or physical distress as defined in
Program guidelines (see back of this form for outline of guidelines)

Representative Signature:_____Date:_____

***Please send completed form to**: The Light A Candle Program: Gritman Medical Center 700 S. Main Street, Moscow, ID 83843*; ***(or) by email to**: lightacandle@gritman.org*; ***(or) fax to**: 208-883-6369*

SECTION 3: LACP Use:_____

Date Request Received:_____Received By:_____

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