Dear Patient,

In order to complete your financial assistance application, we will need the following supporting documentation included with your application:

- **Photo ID**
- **Florida Residency: 2 Forms Required**
- **Proof of Income for Patient and Spouse**
- **Bank statements: copy of 3 most recent statements for all accounts in the patient and spouse's names. (Includes checking, savings, credit union, money market, etc.)**
  ****Please include an explanation of all deposits that are not a direct deposit.****
- **Investments/retirement funds: proof of current value of IRAs, 401Ks, stocks, bonds, CDs, etc. for patient and spouse**

A list of acceptable documentation is enclosed for your reference.

Once we receive your application, we will begin the review process and contact you with updates if additional information is needed.

Contact Information:

New Patients:
813-745-8422 option #1
FAX: 813-745-3792
newpatientfa@moffitt.org

Established Patients:
813-745-8422 option #1
FAX: 813-449-8812
establishedpatientfa@moffitt.org

Mailing Address:
12902 Magnolia Drive
Business Office CB-PFS
Tampa, FL 33612

For your convenience, we have Business Offices located at all facilities where you can drop off your application and supporting documents.

Acceptable Documentation

Identification
- Driver's License
- Pictured Identification Card
- Pictured Student ID Card
- Pictured Employee ID Card
- Homeless Shelter ID Card
- Immigration Documentation
- Military or Dependent ID Card

Florida Residency (2 Forms Required)
- Valid and current Florida driver's license or Florida State ID Card
- Receipt of mortgage, current lease, rental payment, or letter from a landlord
- Most recent tax return or IRS non-filing letter
- Proof of home ownership within Florida
- Homestead exemption document
- Public utility bill for a Florida address in name of applicant or spouse (No cable)
- Florida voter registration card
- Proof of enrollment of applicant's children in a Florida school
- Residency documented through a social service agency
- Written verification from a community agency
- Cancelled mail from a federal, state, or county agency addressed to the applicant or spouse
- Verification from the post office of mail received at a residential address in Florida by applicant or spouse. (Must be proof of residential, not PO Box)
- Homeless Shelter Identification within the state of Florida

Income
- Complete tax return for prior year (All pages are required)
- IRS Non-Filing letter if a tax return was not submitted
- If employed, most recent paystub with year to date (YTD) income information (If YTD is not shown, the 4 most recent paystubs are required)
- Social Security award letter
- Long- or short-term disability award letter or recent paystub with YTD
- Veteran's Benefit award letter or recent paystub with YTD
- Workman's Compensation award letter or recent paystub with YTD
- Unemployment Compensation award letter or recent paystub with YTD
- Pensions or Retirement award letter or paystub with YTD
- Child Support/Alimony (If court ordered, proof from the Standard Disbursement Unit is required)
- Investment/Rental income (Lease or rental agreement)

Assets
- Bank Statements (All pages of last 3 months required for all accounts)
- Money Market Statements (All pages of last 3 months required)
- Stock/Bond Statements (most recent)
- CDs (Savings certificates, most recent statement)
- Trust Fund
- Retirement Funds (IRA/401K/403B, most recent statement)

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME:
MEDICAL RECORD #:

I. RESPONSIBLE PARTY					
LAST NAME	FIRST NAME		MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS					
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?		HOME PHONE
EMPLOYER'S NAME AND ADDRESS					LENGTH OF EMPLOYMENT
POSITION/TITLE				MONTHLY INCOME $	PAY PERIOD
OTHER EMPLOYMENT					SECOND MONTHLY INCOME $

II. SPOUSE		
NAME		DOB
EMPLOYER'S NAME AND ADDRESS		LENGTH OF EMPLOYMENT
POSITION/TITLE	MONTHLY INCOME $	PAY PERIOD
OTHER EMPLOYMENT		SECOND MONTHLY INCOME $

III. HOUSEHOLD INFORMATION (ALL PERSONS IN HOUSEHOLD)			
NAME	DOB	RELATIONSHIP	DEPENDENT ON TAXES?
TOTAL PERSONS IN HOUSEHOLD:			

IV. PATIENT'S UNEARNED INCOME PER MONTH			
SSA/SSI INCOME	$	LONG TERM / SHORT TERM DISABILITY	$
PENSION	$	INVESTMENT/RENTAL INCOME	$
ANNUITY	$	DIVIDENDS/INTEREST	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	VETERANS	$
CHILD SUPPORT/ALIMONY	$	OTHER	$
TOTAL MONTHLY UNEARNED INCOME:	$		

V. SPOUSE'S UNEARNED INCOME PER MONTH			
SSA/SSI INCOME	$	LONG TERM/ SHORT TERM DISABILITY	$
PENSION	$	INVESTMENT/RENTAL INCOME	$
ANNUITY	$	DIVIDENDS/INTEREST	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	VETERANS	$
CHILD SUPPORT/ALIMONY	$	OTHER	$
TOTAL MONTHLY UNEARNED INCOME:	$		

VI. MONTHLY INCOME		
RESPONSIBLE PARTY's MONTHLY INCOME		$
SPOUSE's MONTHLY INCOME (If Applicable)	+	$
TOTAL MONTHLY UNEARNED INCOME	+	$
TOTAL MONTHLY INCOME	=	**$**

VII. ASSETS (IN DOLLARS)			
CHECKING ACCOUNT(S)	$	CD(S)	$
SAVINGS ACCOUNT(S)	$	OTHER	$
INVESTMENTS/IRA's	$		
TOTAL ASSETS:	**$**		

INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED

I certify that the information provided within the application for financial assistance is an accurate and true representation of my financial situation. I authorize Moffitt Cancer Center to verify the information contained herein, including, but not limited to, employment, banking records, social security, and health insurance coverage. I understand providing false information will result in denial of the application for any type of financial assistance through Moffitt Cancer Center. My failure to complete the Application for Financial assistance, including providing supporting documentation, in its entirety within 30 days will result in denial of financial assistance. I understand that I may be contacted by a Financial Counselor to discuss my application and may be required to submit additional documentation. I understand that I remain responsible for outstanding balances while my application is under review and in the event I am approved for partial financial assistance.

SIGNATURE/ DATE:_____/_____

RELATIONSHIP IF OTHER THAN PATIENT:

OVERVIEW OF DRUG ASSISTANCE PROGRAMS

Patients who cannot afford their medication and have been approved for Moffitt's Financial Assistance Program (Charity Funding) also have the option to apply to receive assistance through drug assistance programs sponsored by various drug manufacturers ("Programs"). Generally, the Programs assist qualifying patients in understanding their insurance coverage and financial support options for medications and may provide medication co-payment assistance and/or free medication assistance. If you wish to apply to the Programs, you have the option to allow Moffitt to apply for you. To apply on your behalf, Moffitt will need to share your personal information with the various drug manufacturers to determine whether you qualify for the Programs. If you wish to allow Moffitt to apply to the Programs on your behalf, you must complete and sign the voluntary consent and authorization set forth below.

VOLUNTARY AUTHORIZATION & CONSENT FOR ENROLLMENT IN DRUG ASSISTANCE PROGRAMS BY MOFFITT

I understand that before I may receive assistance from the Programs, the Programs will need to obtain, review, use, and disclose my personal information to determine if I qualify for the Programs. Such personal information includes, without limitation:

1. Your contact information and date of birth provided to Moffitt from you;
2. Your Social Security number provided to Moffitt by you
3. Your professional and employment information provided to Moffitt by you;
4. Your financial and income information provided to Moffitt by you;
5. Your health insurance information;
6. Your health records and information, including medications; and
7. Your biometric and genetic information, including tests that identify the kind of illness that you have and/or medication indicated for your treatment (collectively and individually "Personal Information").

I therefore authorize and permit Moffitt and its authorized agents to apply on my behalf to the Programs, to complete all necessary applications for the Programs, and to disclose my Personal Information to various drug manufacturers and their authorized agents, representatives, administrators, employees, and contractors (collectively the "Program Administrators")i n order to verify my eligibility to enroll in the Programs, to help identify Programs for which I may qualify, and to enroll me in the Programs for which I am eligible.

I also authorize the Programs and the Program Administrators to: (i) share my Personal Information with one another and with my physicians, pharmacists, and other health care providers, as well as with Medicare, my health plans, and their administrators, contractors, or representatives, in order to coordinate my benefits, provide reimbursement support, and investigate my insurance coverage; and (ii) disclose and utilize my Personal Information to ensure compliance with the rules of the Programs.

Even though the intended use of my Personal Information is for the purposes described in this authorization, I also understand that the Personal Information disclosed pursuant to this authorization, once disclosed, may no longer be protected by federal privacy law. I understand that I may cancel this authorization at any time by contacting the FCU Copay Assistance Team via email at FCUCopayAssistance@moffitt.org or by phone at 813-745-7300 option 2. I understand that canceling my authorization will mean that Moffitt, the Programs, and the Program Administrators may no longer rely on the authorization to use or disclose my Personal Information, but that any use or disclosure of such information that occurs before my cancellation is received and processed will be unaffected by my cancellation.
I understand that if I do not cancel this authorization, the authorization will expire one (1) year from the date of my signature below. I understand that I am entitled to receive a copy of this authorization once it has been signed. I also

understand that in the event I qualify for a Program(s), I may need to reapply periodically and sign a similar authorization as part of such reapplication. I certify that the Personal Information that I have provided to Moffitt is true and complete, and I understand that Moffit will be providing this Personal Information to the Programs. I agree that, at any time during my participation in any Programs, Moffitt may request additional documentation to verify my Personal Information. If there is missing information or I do not respond to requests for additional documents, my participation in the Program(s) may be delayed or I may no longer be able to participate. If I qualify for and receive co-pay assistance, free medication assistance, or any other assistance from the Programs, I agree to comply with all Program rules from which I receive assistance. I also agree that I will not get reimbursed for the Program assistance I receive from anyone else, including from an insurance program, another charity, or from a healthsavings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary. I will contact Moffitt if my insurance or treatment changes in any way. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Programs.

By checking the "Consent & Authorization" box below, I agree and acknowledge that I have read and understand this voluntary authorization and consent, and that I authorize Moffitt through its authorized agents to complete and submit the Program applications on my behalf utilizing my Personal Information. I understand that this Personal Information may be obtained from me, my Moffitt physicians and other care providers, my Moffitt medical record, my health plans, and other sources. I understand that application to the Programs is voluntary and that if I refuse to apply, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Programs.

☐ Consent & Authorization

_____ Patient Signature