I A M R E N A D A Y

FOUNDATION

Thank you for your interest in our iSupport Care Program. Our program offer insurance coverage assistance to uninsured women and men who meet the pre-defined eligibility criteria. Please complete each section of the application form as indicated below. For us to process the application, it must be complete and legible. Each block, line, or space must have an entry. If something does not apply, please write in N/A. Unfortunately, incomplete applications will delay the review process and final determination.

Instructions for Provider (5 steps)	Instructions for Patient (5 steps)
1. Complete the Provider Information Section (II)	1. Complete the Patient Information (Section I)
2. Include State License or NPI Number	2. Complete the Financial Information (Section IV) including: • All sources of household monthly income
3. Application must be submitted with signature from PROVIDER and PATIENT	3. Attach proof of income (required) • Last year's tax return • Letter of support Other acceptable documentation: • 1040, 1040A, 1040EZ • W2 • 1099 • Social Security Statements
4. Complete and sign the Application Form (Section II)	4. Complete and sign the Application Form (Sections IV)

Please fax and sign the completed application with required documents.

(PATHOLOGY REPORT OR SCANS SHOWING PROOF OF CANCER DIAGNOSIS MUST BE FAXED)

IAMRENADAY FOUNDATION iSUPPORT CARE PROGRAM

P.O. Box 831534 • Ocala, Fl. 34483

FAX: 352-292-4559 EMAIL: rday@iamrenaday.org

iSUPPORT CARE APPLICATION FORM

I AM RENADAY FOUNDATION

Please print clearly. All items must be complete, or application will be returned.

PATIENT INFORMATION (SECTION I)

Patient Name	Primary Phone Number	Secondary Phone Number
Street Address	Social Security Number or Green Card Number	US Resident Yes ☐ No ☐
City **State** **Zip Code**	Date of Birth / /	Gender ☐ M ☐ F
Mailing Address ☐ Same as Address Above	Check Number of People in Household (include self) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+	
City State Zip Code	List any drug allergies	
Have you ever been diagnosed with Cancer? ☐ Yes ☐ No	Do you have medical insurance? ☐ Yes ☐ No	List any medications you are currently taking:

PROVIDER INFORMATION (SECTION II)

Provider Name	NPI Number	State License Number
Street Address		Office Contact Name
City State Zip Code	Phone Number	Fax Number

Original signature required. Stamped signature **ARE** not allowed

Providers Signature X	**Date**

INFORMATION (SECTION III)

*** Please provide **CANCER** diagnosis below***

Has Chemotherapy Started? YES ☐ NO ☐	Date	ICD-10	Type of Cancer
	List of Chemotherapy drugs		

FINANCIAL INFORMATION (SECTION IV)

ATTACH PROOF OF INCOME (Do not send original documents) If patient does not have proof of income please provide a letter of support

I hereby consent to allow IAMRENADAY Foundation to use and/or disclose this information to any third party engaged to assist with program requirements. I understand that this information will be used to determine my eligibility for participation in the iSupport care program, and that IAMRENADAY Foundation reserves the right at any time for any reason to contact me and to request additional information. By signing below, I verify that the information in this application, including all copies of documentation, is complete and accurate, and that I am authorized to sign this application. I understand that the information used or disclosed may be subjected to re-disclosure and protected by HIPAA. I understand that IAMRENADAY Foundation and any third party engaged to assist has the right to verify my eligibility, including the right to audit any information provided. I also agree that I will contact IAMRENADAY Foundation if any of the information that I have provided may affect my approval process. I also understand that IAMRENADAY Foundation has the right to contact me directly to confirm receipt of chemotherapy, cancer diagnosis and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation at any time by either calling or mailing a letter to IAMRENADAY Foundation.

Patient's Signature X	**Date**

APPOINTMENT OF A DESIGNATED REPRESENTATIVE

Case Number

Customer's Name

Completed by Customer

I would like for Rena Day (IAMRENADAY FOUNDATION) to act on my behalf in determining my eligibility for public assistance from the Department of Children and Families.

Name of Representative

Signature of Customer

Date

Completed by Representative

I understand that by accepting this appointment, I am responsible to provide or assist in providing information needed to establish this person's eligibility for assistance. I understand that I may be prosecuted for perjury and/or fraud if I withhold information or intentionally provide false information.

Signature of Representative

Date

Relationship to Customer: Patient Advocate

Street Address: P.O. Box 831534

City: Ocala

State: Florida

34483

Phone Number: 305-495-6649

Self-Appointment by Representative

I am acting for _____ in providing information to establish eligibility for assistance because he/she is unable to act on his/her own behalf. I will provide information to the best of my knowledge. I understand that if I withhold information or if I intentionally provide false information, I may be prosecuted for perjury and/or fraud. I agree to immediately report any change in their situation of which I become aware.

Signature of Representative

Date

Relationship to Customer

Street Address

City

State

Phone Number