Gritman | LIGHT A CANDLE

INITIAL REQUEST FORM

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

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

(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*; email to: lightacandle@gritman.org ***(or) fax to**: 208-883-6571*

SECTION 3: LACP Use:

Date Request Received:_____Received By:_____

Gritman Foundation