

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





	SECTION 1: PA	TIENT INFORM	MATION:		LAC NUMI	BER:		
Patient Name:								
Address				City:_				
State:	ZIP Code:		_County:					
Is the patient 18 year	rs or older?	_YN If no,	patient gua	ardian name?				
Phone:								
DOB:								
Date of Diagnosis								
Please check service								
(OR) - Please provid	e description of	requested servi	ce(s) neede	ed:				
Initial request (other t As the initial requesto application: Patient Signature: (Unsigned application	r, please have pat	ient sign request t	to give his or	her consent to	o provide in	formatio	n as requi	ired for
		CERTIFIED REP						
Physician Name:			Pł	ıysician Telep	ohone:			
Representative Nam	ıe:		7	Γitle:				
Representative's Ho	spital or Clinic N	Name:						
Telephone:	E	mail:			Fax:			
*Applications are only acceptocial worker. All sections of Consideration shall be determined.	of this form must be tr	uthfully completed. Ar	y false, incomp	lete or misleading	information w	ill result in	n an automat	
*By signing this application (a) I am the representative (b) The patient or patient's (c) The information provide (d) I hereby give LACP my c (e) I verify that the patient in defined in Program guidelines (see bat Panyasantativa Sign	listed above, and I am guardian has given his ed in this application is consent to use my infoneets criteria: 1) Patick of this form for out	authorized to submit s or her consent to pro s truthful and accurate rmation and contact m ent is under active trea	evide the inform to the best of note to discuss the eto discuss the etment for cance	nation in this appli ny knowledge. e request in this ap	cation. oplication and a	any related eed or phys		
Representative Sign <i>Please send complete</i>		aht A Candle Prog	ram: Gritma	n Medical Cente			Moscow	 ID
83843; (or) by email t						50, 666	- 10000 11, 1	
		SECTION	3: LACP Us	e:				
Date Request Receiv	rod:		Received Ry					

Gritman Foundation