Sangamon County Medical Society Foundation
with funding provided by
Susan G. Komen – Memorial Affiliate

Breast Cancer Patient Assistance
Intake Form

In order for the Sangamon County Medical Society Foundation to provide the best service possible, we ask that referred patients complete the front of this form, and the referring physician/physician contact completes the back of this form in its entirety. The information provided will be kept confidential. Thank you for your cooperation.

Please Print

Date: ________________________________

Name: ____
(First) (MI) (Last) (Maiden)

Street Address: _____________________________________ Phone: __________________

City: __________________________ State: ______ County: ____________ Zip: _______

Gender: _______________ Race: _______________ Birth Date:_______________

❑ Medicaid ❑ Medicare ❑ Insurance ❑ None

Sangamon County Medical Society Foundation
Certification and Consent to Release Information

I certify that the information I have provided is true and complete to the best of my knowledge and belief. I authorize Sangamon County Medical Society Foundation, in the course of processing my request for assistance, to release any or all of this information to relevant outside parties when it deems it necessary to do so in order to expeditiously and effectively process my request. I hereby authorize any vendor, landlord, utility, lending institution, or human service agency to release to Sangamon County Medical Society Foundation any information regarding my account with them (including, but not limited to account number, balance due, and payment history), my financial background and my history of services received from them. This authorization expires when this episode of assistance has been resolved. (A photocopy of this consent to release information shall be as valid as the original)

_____________________________________ (Signature of Client)

__________________ (Date)

Breast Cancer Patient Assistance
Referral Form

Referral To: Sangamon County Medical Society Foundation
Phone: (217) 726-5106 Fax: (217) 726-5403
Email: scms@scmsdocs.org

Referring Physician: ____

Medical Group: ____

Physician's Contact: ____

Phone: ______________________ Fax: ________________________

Patient Advocate: ____

Phone: ______________________ Fax: ________________________

Item Needed: (Requests granted are based on the availability of funds provided by Susan G. Komen Grants.)

- ❑ Gas Voucher Dollar Amount Requested: $_______________
- ❑ Grocery Voucher Dollar Amount Requested: $_______________
- ❑ Medical Supplies Dollar Amount Requested: $_______________
  Supplies Needed: ____
- ❑ Other: ____

____________________________________ ____________________
(Signature of Physician/Physician's Contact) (Date)

Sangamon County Medical Society Foundation Use Only

Items Provided: ____

Dollar Amount Provided: _______________________________

Date: ______/______/______