P.O. Box 722767 ● Norman, OK 73070 ● (405) 793-ALLY (2559) or 877-730-2559

Application for Financial Assistance

Section 1 – Patient Information

Name (First, Middle, Last)	Diagnosis	Social Security Number - -	
Address (Street, City, State, Zip)	Approx. Length of Treatment:	Gender ☐ M ☐ F	Date of Birth

Does patient have health insurance? ☐ **Yes** ☐ **No** If yes, provide:

Insurance Company: _____ Policyholder (insured person): _____

Section 2 – Parent/Guardian Information

MOTHER / GUARDIAN'S INFORMATION			
Mother's / Guardian's Name	Social Security Number	Phone	☐ Cell ☐ _____
Address (Street, City, State, Zip)	Employer	*Email	
FATHER / GUARDIAN'S INFORMATION			
Father's / Guardian's Name	Social Security Number	Phone	☐ Cell ☐ _____
Address (if different from above)	Employer	*Email	

**IMPORTANT: Email is an important communication tool. Please provide an email address that is checked regularly.*

Section 3 – Parent/Guardian Certification

I certify the information provided in this application is true and correct as of the date of my signature and any intentional misrepresentation of information in this application will result in the loss of assistance from Ally's House and may result in civil liability. Applicant releases Ally's House from all liability arising from the sharing of information in establishing eligibility for assistance.

X _____ _____ _____

Parent/Guardian Signature **Date** **Relationship to Patient**

Section 4 – Parent/Guardian Consent for Release of Protected Health Information

I, _____ (check) ☐ Patient ☐ Parent, ☐ Guardian, ☐ legal custodian of the above listed patient, authorize physicians and staff treating this patient to release to Ally's House the following information:

☐ Diagnosis _____ (type of cancer)
☐ Date of Diagnosis: _____/_____/_____
☐ Projected Length of Treatment (based on current protocol): _____ ☐ weeks ☐ months ☐ years

I understand that I am authorizing the release of this information for the purpose of qualifying for financial assistance and/or other support, and that my consent is continuous unless I revoke such consent in writing at a later date.

X _____ _____ _____

Parent/Guardian Signature **Date** **Relationship to Patient**

Section 3 – Physician Certification

I certify that the patient listed in this application is ***currently receiving treatment for a form of cancer*** from: (*check one*)
☐ OU Children's Hospital/Clinics; or ☐ St. Francis Hospital; or ☐ _____.
(name of hospital or treatment facility)

X _____ _____

Physician Signature **Date**