Fleener Family Foundation

Cold Cap Subsidy Application

Patient Information

Full Name _____ Gender _____

Full Address _____

Phone _____ Email _____

Date of Birth _____ Social Security Number _____

Diagnosis Information

Type of Cancer _____ Stage _____

Type of Chemotherapy _____

Rounds _____ Frequency _____

Anticipated Start Date _____

Oncologist Name _____ Phone _____

Is your oncologist supportive of cold cap therapy? _____

Treatment Center Name _____

Full Address _____

Phone _____

Eligibility Information

Household Income _____ Household Size _____

Type of Insurance _____

Have you applied for insurance coverage _____

If so, did your insurance deny insurance coverage _____

Can you provide a copy of the denial letter _____

With your signature below you acknowledge and agree to the following:

- All information provided is true
- Permission is granted to contact you by phone, mail or email
- You agree the Fleener Family Foundation (“Foundation”) can contact your oncologist to verify your information
- The Foundation may ask you for documentation of your income including the first page of the most recent tax return or a copy of your SSA 1099 if applicable
- You will notify the Foundation immediately if insurance approves cold cap therapy on your behalf
- You agree to a post treatment survey which can be used at the Foundations discretion with all personal details removed for your privacy

Signature _____

Printed Name _____

Date _____