Support Healing

Medical Team Contact Information Form

Please provide the **name, email address, and phone number** for the following providers. We may contact them if we can't reach you or need further information.

NAME	POSITION	EMAIL ADDRESS	PHONE
	Social Worker		
	Nurse Navigator		
	Patient Advocate		

Please read the statements below and initial where indicated:

I understand Support Healing does not pay for medical expenses of any kind. _____
Initials

I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy, and/or I am currently undergoing chemotherapy or radiation. _____
Initials

I give my full authorization and permission to Support Healing to obtain the necessary medical information to process my application. _____
Initials

I understand Support Healing may ask personal questions about my treatment and financial status; I agree to provide accurate and truthful answers. _____
Initials

I understand that Support Healing may conduct a follow-up survey. _____
Initials

I understand Support Healing is not liable for any cost incurred in the submission of this application for financial support. _____
Initials

I understand my application will be held for 7 years in accordance with Support Healing's retention policy and **will not be returned.** _____
Initials

I understand that if I have falsified information on my application for funding or have withheld information regarding Support Healing's definition of active treatment or my employment status, I will be required to immediately reimburse Support Healing for any payments administered on my behalf. **Support Healing reserves the right, in its sole discretion, to suspend any further payments that I have been awarded**. _____
Initials

Applicant's Signature:_____ Date: _____