Emerald Coast Cancer Center
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FINANCIAL QUESTIONNAIRE FOR DRUG REPLACEMENT AND COPAY ASSISTANCE

Information is being requested for the sole purpose of registering our patients in patient access programs in order to improve our services offered to you. These programs offer copayment / out of pocket assistance to those that qualify, and many programs will replace the medication free of charge if we receive a denial from your insurance. Please fill out the following questions below and if possible please bring your most current tax return or other financial information (one month of recent paystubs or SSI Award Letter) to your next visit. All information will be kept confidential. Please let us know if you do not want to share this information.

Patient Name: _____ **Date Of Birth:** _____

How many in household?: _____

What is total income that was claimed on most recent tax return?: (if income has changed from amount claimed please provide new income amount.)

_____

_____

_____

_____

Please initial in box if you choose to decline patient assistance/drug replacement at this time. ☐

Patient Signature: _____

Date: _____

****ALL INFORMATION PROVIDED WILL BE KEPT COMPLETELY PRIVATE AND CONFIDENTIAL****

FORM WILL NEED TO COMPLETED YEARLY.