www.therealteal.org info@therealteal.com

Requirements

- Person applying must be actively undergoing treatment for ovarian cancer.
- Cancer's originating site must be the ovaries.
- Patient must be a U.S. citizen and reside in Northeast Florda, supported by a valid driver's license (Northeast Florida includes Baker, Clay, Duval, Nassau, Putnam and St. Johns counties).
- The application must be completed in full.

We want to get to know you

Patient's Full Legal Name			
Phone #		Birthday	
Address			
City		Zip Code	
U.S. Citizen	Yes No	Date of Application	

Health Insurance Information

Do you have health insurance?	Yes No		
If yes, please indicate types	Private Health Insurance	Emergency Medicaid	Medicare
	Veteran's Assistance Program	Medicaid	Other
Insurance Company		Phone #	
Policy Holder Name		Deductible	
Are you receiving or have you received assistance in the past 12 months?	Yes No	Do you have prescription drug coverage?	Yes No
If you answered yes to the above, please detail where from and how much.			

Monthly Expenses

Rent / Mortgage		Auto Payment	
Utilities		Health Insurance	
Phone		Medications	
Child Care		Food	
Other Medical			
Other			

All information is confidential and solely for The Real Teal. Information will not be shared or sold.

The Real Teal

Patient's Full Legal Name

www.therealteal.org info@therealteal.com

Financial Assistance Request

Please describe the request for financial support:

Amount Requested: $_________________________

Your Checklist

A legible copy of your current government issued photo ID.

Print patient name at the top of pages 2 and 3.

Sign and date page 3 of 3 - electronic signatures cannot be accepted.

Doctor's portion completed on page 3.

All 3 pages of the application completed and sent to therealteal@therealteal.com.

Patient's Full Legal Name

www.therealteal.org info@therealteal.com

Release of Information

I, the undersigned, hereby acknowledge that the information provided is complete and accurate to the best of my knowledge and belief. I understand that by submitting this application, I am granting The Real Teal permission to contact the provider completing the medical referral portion of this application to verify the information provided. I understand funding is limited and based on availability and feterminiation of eligibility. My signature also indicates that I will assume all liability for the services and providers paid for with funds provided by The Real Teal and agree to hold The Real Teal harmless of any and all negligence, omission, misconduct or fraud in the performance of all work from any services hired by, or on behalf of, the recipient.

Patient Signature ______________________ Date ______________

Medical Referral

This portion must be completed by the patient's oncologist.

Name of Oncologist:		Phone Number	
Institution / Name of Practice		Fax Number	
Primary Tumor Type and Grade		Email	
Date of Diagnosis			

Treatment Plan / History:

Written Name ______________________ Specialty ______________

Doctor's Signature ______________________ Date ______________

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