Hospital Referral & Financial Assistance Application

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Instructions

Please complete all sections. A referring provider or hospital staff member should fill out this form on behalf of the patient. Once complete, save and email this form to darren@mindsovertumors.org. Applications are reviewed to determine eligibility for financial assistance. Fields marked with an asterisk (*) are required.

Financial assistance is awarded on a case-by-case basis, up to a maximum of $2,500 per patient, subject to review and availability of funds. Submission of this form does not guarantee an award.

Section 1 — Patient Information

Patient Full Name *			
Preferred Name			
Date of Birth *		**Age ***	
Gender		**Phone Number**	
Email Address			
Home Address *	(Street)		
City *		**State ***	
ZIP Code *		**Country**	

Preferred language / interpreter needed:

Section 2 — Diagnosis & Medical Information

Type of Brain Tumor *	(e.g., Glioblastoma, Meningioma)
Tumor Grade / Stage	
Date of Diagnosis *	
Diagnosing Physician	

Current treatment status:

☐ Newly diagnosed ☐ In active treatment ☐ Post-treatment / monitoring ☐ Recurrence

Type(s) of treatment received or planned:

☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Clinical trial ☐ Other

Brief summary of diagnosis and prognosis (optional):

Section 3 — Treating Hospital / Facility

Hospital / Facility Name *			
Department / Unit			
Hospital Address *	(Street)		
City *		**State ***	
ZIP Code *		**Main Phone**	

Section 4 — Financial Assistance Requested

Type of assistance needed (check all that apply): *

☐ Treatment / medical bills ☐ Medication costs ☐ Travel to treatment

☐ Lodging near treatment ☐ Household / living expenses ☐ Medical equipment

☐ Childcare / dependent care ☐ Other (describe below)

Please describe the specific need and, if known, the estimated amount:

Estimated cost of the specific need	$
Amount requested (up to $2,500)	$
Is the patient insured?	☐ Yes ☐ No ☐ Unknown
Other aid being received?	☐ Yes ☐ No (if yes, describe)

Urgency of need:

☐ Immediate ☐ Within 30 days ☐ Within 90 days ☐ Ongoing

Section 5 — Referring Person / Form Completed By

Full Name *	
Role / Title *	(e.g., Oncology Social Worker, Nurse)
Department	
Email Address *	
Direct Phone *	

Relationship to patient:

☐ Treating physician ☐ Nurse ☐ Social worker ☐ Case manager ☐ Other

Best way and time to reach you:

Section 6 — Patient Authorization for Release of Health Information

This authorization must be signed by the patient or the patient's personal representative before any protected health information is shared with Minds Over Tumors. Hospitals should confirm this authorization meets their own institutional release requirements before disclosing information.

By signing below, I authorize the disclosure of my protected health information as described here:

Information to be disclosed: the patient's name, contact information, age/date of birth, brain tumor diagnosis, diagnosis date, treatment status and history, treating facility, and financial-need information contained in this form.

Who may disclose it: the treating hospital, facility, and providers named in this form.

Who may receive it: Minds Over Tumors and its authorized staff reviewing this application.

Purpose: to evaluate the patient's eligibility for financial assistance and to administer any assistance provided.

Right to revoke: I understand I may revoke this authorization at any time by writing to darren@mindsovertumors.org, except to the extent action has already been taken in reliance on it.

No conditioning: I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this authorization.

Redisclosure: I understand that information disclosed under this authorization may no longer be protected by federal privacy law once received by Minds Over Tumors, though the organization agrees to use it only for the purpose stated above.

Expiration date of this authorization	(or state an event, e.g. “end of assistance review”)

Patient / Representative Signature	**Printed Name**	**Date**
If representative: relationship to patient		

Section 7 — Referring Party Attestation

I confirm that the information in this form is accurate to the best of my knowledge, that I am authorized to submit it on the patient's behalf, and that the patient (or their authorized representative) has signed the authorization in Section 6 permitting this disclosure.

Referring Party Signature	**Date**

Save this completed form and email it to darren@mindsovertumors.org

For internal use only — do not write below this line

Date received	**Reviewed by**	**Decision**