Fight the Good Fight, Inc.
Patient Co-Payments/Clinical Trial/Medical Relief Assistance Program Application form for Patients Diagnosed with Primary Brain Tumors

Overview

Fight the Good Fight is a nonprofit 501(c3) organization dedicated to helping patients diagnosed with Primary Brain Tumors.

This program can help adults 18 and older pay for chemotherapy and targeted treatment drugs, clinical trial medication, blood work related to treatment diagnosis, PET Scan/MRI Scan/CT Scans related to the diagnosis, Medical Relief of hospital/ambulatory care related to treatment and diagnosis if you meet the qualifications and if we have funds remaining. There is never any cost to you. You can use any doctors and treatments you like-we will never ask you to switch.

In order for us to begin the process of qualifying you for assistance, please complete the enclosed application and return it to Fight the Good Fight, along with verification of your household income and copies of your insurance card(s). Completed applications can be received via mail or via email. Details of Guidelines are on page two and three. Details of acceptable documentation and submission options are outlined on page four. Upon receipt of your completed application, we will contact your treating physician to verify your diagnosis and will determine if you are eligible for copayment assistance based on our program guidelines and available funding.

If you qualify and if funding is available, we will provide you with copayment assistance for one year from your approval date. After that year you may reapply for a copayment assistance program.

To reiterate, you must fill out the enclosed paperwork, sign it and return it to Fight the Good Fight, along with your income documents and insurance cards in order to be considered for funding. Please understand that all approvals are based on available funding and are approved on a first-come, first-served basis. Receipt of an application does not guarantee funding.

If you have any questions or need assistance filling out the enrollment forms please do not hesitate to contact us via email at fightthegoodfight17@gmail.com

Sincerely,

Linda C. Arrieta
Executive Director
Fight the Good Fight
PO Box 2574
Huntersville, NC 28078

Guidelines

Diagnoses we Cover

Primary Brain Tumors in adults: A primary brain tumor is a group (mass) of abnormal cells that start in the brain.

Primary Brain Tumor in Adult List:

- Astrocytic tumors include astrocytomas (can be noncancerous), anaplastic astrocytomas, and glioblastomas.
- Oligodendroglial tumors. Some primary brain tumors are made up of both astrocytic and oligodendrocytic tumors. These are called mixed gliomas.
- Meningiomas
- Schwannomas
- Ependymomas
- Craniopharyngiomas
- Pituitary tumors
- Primary (central nervous system - CNS) lymphoma
- Pineal gland tumors • Primary germ cell tumors of the brain

Primary Pediatric Brain Tumors: Are a mass or growth of abnormal cells that occur in a child's brain or tissue and structures that are near it.
https://www.mayoclinic.org/diseases-conditions/embryonal-tumor/cdc-20367985

Primary Pediatric Brain Tumor List:

- Choroid plexus carcinoma
- Craniopharyngioma
- Embryonal tumors
- Ependymoma
- Glioma
- Medulloblastoma
- Pineoblastoma

Products we Cover

Our foundation covers all products for your chemotherapy and targeted treatment drugs, blood work related to treatment diagnose, PET Scan/MRI Scan/CT Scan related to the diagnose, Medical Relief of hospital/ambulatory related to treatment diagnosis, including generic or bioequivalent drugs, as prescribed by the patient's physician to treat his/her primary cancer diagnosis as long as the medication has been approved by the Food and Drug Administration (FDA), is classified as a chemotherapy or targeted treatment drug, and covered by the patient's primary insurance provider.

In the case of a clinical trial in which the drug has not been approved by the FDA, but the IRBs has approved the clinical trial protocols, which describe the type of people who may participate in the clinical trial, the schedule of tests and procedures, the medications and dosages to be studied, the length of the study, the study's objectives, and other details. IRBs make sure the study is acceptable, that participants have given consent and are fully informed of their risks, and that researchers take appropriate steps to protect patients from harm.

We will cover the following for clinical trials:

- Doctor visit copays
- Hospital stays
- Lab tests copays
- X-rays and other imaging tests copays

Required Documentation & Submission Option

1. Pages 5-9 signed and dated where applicable along with income verification documentation.
2. Signed copy of your most recent US Federal Income Tax Return (IRS Form 1040, 1040A, 1040EZ) For Individuals who did not file an Income Tax Return last year, you must submit: * A copy of your most recent Social Security/Disability Award Letter, Benefit Statement or monthly check * A copy of your most recent paycheck/pension stub * A copy of your Unemployment Check or Benefit Notification
3. A copy of the front and back of the Patient's insurance card(s) Submission Options

You can return your completed application the following ways:

Via Mail:
Fight the Good Fight
PO Box 2574
Huntersville, NC 28078

Directions: Please fill out the application below and return via mail. Return pages 5-8 along with the information requested on page 4.

Date:	Patients Last Name:	Patients First Name:	MI	S.S. #
DOB:	Home Address:	City:	State	Phone No:
Marital Status: __M ___S___W___D	Mailing Address:	City:	State	
Email Address:	Alternate Contact Name:	Relationship:		Contact Number:
Contact Email Address:				
Physicians Name:	Phone Number:	Address:		
Diagnosis Information:				

****THIS PAGE MUST BE RETURNED***

Insurance Information

Remember to include a copy of your insurance card back and front.

Insurance Co. Name	Group No.	ID No.	Insurance Phone No.

****THIS PAGE MUST BE RETURNED***

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information" or "PHI") as described below in this form (this "Authorization") Fight the Good Fight. Name of person(s) or organization(s) authorized to use or receive the Protected Health Information: Fight the Good Fight affiliates, contractors, vendors, agents, sponsors, and donors Specific description of Protected Health Information to be used or disclosed: Demographic information, contact information, diagnosis, date of birth, social security numbers, disease, drug treatment information, and other individually identifiable health information. The purpose of the disclosure of Protected Health Information is to: (i) make determinations for financial assistance; (ii) communicate with your provider regarding your patient assistance for payment and therapy management purposes; (iii) fundraise; and (iv) provide and notify you of, additional programs and services available through Fight the Good Fight. Please fill out an event on which this authorization will expire: Upon written request from patient Please read the following: 1. I understand that my Protected Health Information may be subject to re-disclosure by the authorized recipient of the PHI pursuant to this Authorization and no longer protected by federal or state privacy regulations. 2. I understand and authorize Fight the Good Fight to de-identify, reidentify and attempt to re-identify me and my Protected Health Information. 3. I understand that my Protected Health Information is subject to electronic disclosure. 4. I understand that I may revoke this Authorization at any time by notifying Fight the Good Fight, in writing, but if I do, it will not have an effect on any actions Fight the Good Fight took before it received the revocation of this Authorization.

Revocations must be sent to:

Fight the Good Fight
PO Box 2574
Huntersville, NC 28078

Section B: The patient or the patient's representative must read the following statements: I understand that I may refuse to sign the Authorization, and that my health care treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this form. However, I understand that my enrollment and eligibility to participate in Fight the Good Fight programs and receive co-payment assistance is conditioned upon signing this form. I understand that I have the right to receive a copy of this Authorization after I sign it. Section C: By signing below you agree that you have read and understand the above statements. (Form MUST be completed before signing.)

____

Signature of Individual or Individual's Legal Representative / Date

____

Print name of Individual's Legal Representative: (If applicable) Relationship or Authority to Act

You must be a legal or authorized representative for the applicant in order to sign this authorization on his/her behalf. ****THIS PAGE MUST BE RETURNED***

Patient Attestation

Directions: Circle Yes or No to the questions below:

Yes / No Are you receiving Pharmacy Benefits paid for by Medicare, Medicaid, or any Federal or State funded insurance or assistance program?
Yes / No Do you agree that the Diagnosis listed on the application is your primary cancer diagnosis and the chemotherapy medication prescribed is for the treatment of that diagnosis?

Certification and Acknowledgement: You agree that all of the information you have provided is truthful and accurate to the best of your knowledge. You understand that you are free at any time to switch providers, practitioners, suppliers, or medications within the Fight the Good Fight formulary for your diagnosis without affecting your continued eligibility for assistance. Your application for assistance does not guarantee funding will be available. Any financial assistance that you may be eligible for will only be awarded after documentation of your first dispense has been approved by Fight the Good Fight. You understand that if you are awarded financial assistance that it will be provided for a period of one year and that you must reapply annually. There is no guarantee that funding will be available in any subsequent year. The Foundation cannot keep funds reserved for an individual beyond 90 days from the award effective date. Delay or significant lapse in claims submitted can result in termination of your award. If this happens and you still require assistance, your case will be re-evaluated based on funding availability at that time.
Limitation of Liability: You agree that Fight the Good Fight and our affiliates, contractors, vendors, agents, sponsors, and donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, copayment relief, or other value-added benefits or services provided as a part of this program.

____

____________________________ Signature of Individual or Individual's Legal representative Date (Form MUST be completed before signing)

____

_____________________________ Print Individual Name of Individual's Legal representative Relationship or Authority to Act You must be a legal or authorized representative for the applicant in order to sign this authorization on his/her behalf.

****THIS PAGE MUST BE RETURNED***