The Edward M. Calvo
CANCER FOUNDATION
"GUAM IS GOOD."

PATIENT SERVICES APPLICATION FORM

Please complete and sign the application and provide **a copy of Guam government issued photo identification card**. Please also return the completed and signed Physician's Certification Form.

NAME (LAST, FIRST, M.I.)		
PHYSICAL AND MAILING ADDRESS		
DATE OF BIRTH	**PLACE OF RESIDENCY**	
EMAIL	**ETHNICITY**	
HOME PHONE NUMBER	**WORK PHONE NUMBER**	**FAX NUMBER**
PRINCIPAL CONTACT/CAREGIVER	**RELATIONSHIP**	**PHONE NUMBER AND EMAIL**

Have you previously applied for assistance from the Edward M. Calvo Cancer Foundation?
YES NO

If so, please provide the date(s) of your previous application(s):

_____

What type of cancer have you been diagnosed with?

_____

When were you diagnosed with cancer? _____

Who referred you to the Edward M. Calvo Cancer Foundation?

_____

If you are approved for assistance from the Edward M. Calvo Cancer Foundation, may we contact you to provide a testimonial? YES NO

If this application is approved by the Edward M. Calvo Cancer Foundation, I will use the funds provided to me to pay for the following costs and expenses arising from or related to my cancer treatment (PLEASE CHECK ALL THAT APPLY):

☐ doctor appointments ☐ cancer treatment (surgery, radiation therapy, chemotherapy infusion, medication) ☐ medication (drugs prescribed during before or after treatment to manage side effects) ☐ transportation ☐ support services/counseling ☐ at-home care	☐ short-term housing during off-island treatment ☐ cosmetic items to address side effects (wigs, prostheses) ☐ equipment (wheelchairs, crutches) ☐ other (please specify): _____ _____ *funds may not be used for legal fees (e.g. estate planning or drafting a will)

I certify under the penalty of perjury that all of the information provided as part of this Patient Services Application is true, complete and accurate. I understand that the information supplied in this application is subject to verification by the Edward M. Calvo Cancer Foundation. I further understand that failure to disclose information requested in this application or disclosure of erroneous information will cause the application to be denied.

I UNDERSTAND THAT BY SUBMITTING THIS APPLICATION AND SUPPORTING DOCUMENTS AND BY SIGNING BELOW, I AUTHORIZE THE EDWARD M. CALVO CANCER FOUNDATION TO REVIEW ANY AND ALL MEDICAL INFORMATION PROVIDED. THIS CONSENT ALSO INCLUDES ANY RELEASE OR EXCHANGE OF INFORMATION NEEDED BY THE EDWARD M. CALVO CANCER FOUNDATION FOR REQUESTED ASSISTANCE ON MY BEHALF. I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME.

SIGNATURE: _____ DATE: _____

If applicant is unable to sign, applicant's guardian or personal representative must sign below:

REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____

REASON THAT APPLICANT IS UNABLE TO SIGN: _____

CHECK RECEIVED BY: (PRINT NAME AND SIGN)	**DATE:**

FOR EMCCF USE ONLY	**GRANT ISSUED ON:**	**CHECK NO.**

PHYSICIAN'S CERTIFICATION FORM

_____ has applied for services from the Edward M. Calvo Cancer Foundation.

THE APPLICANT/GUARDIAN, BY SIGNING BELOW, HEREBY GIVES PERMISSION TO HIS/HER PHYSICIAN TO RELEASE THE HEALTH INFORMATION LISTED BELOW:

NAME (LAST, FIRST, M.I.)	**SIGNATURE**	
ADDRESS		
DATE OF BIRTH	**PHONE NUMBER**	**DATE**

PLEASE HAVE THE PHYSICIAN COMPLETE THE FOLLOWING AND RETURN THE COMPLETED FORM TO THE EDWARD M. CALVO CANCER FOUNDATION

PATIENT'S NAME (LAST, FIRST, M.I.)
DIAGNOSIS(SPECIFY TYPE OF CANCER)
THIS PATIENT: ☐ **HAS ACTIVE CANCER** **OR** ☐ **IS IN REMISSION**

PHYSICIAN'S NAME _____

CLINIC NAME AND ADDRESS _____

_____

CLINIC PHONE NO. _____ CLINIC FAX NO. _____

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S MEDICAL RUBBER STAMP

DATE _____
(must be within 60 days of submission of the application to the Edward M. Calvo Cancer Foundation)

REVISED 9/2021