At **Willamette Valley Cancer Institute and Research Center (WVCI)**, we are committed to alleviating the financial burden on our patients. Our dedicated team will diligently work to review and enroll eligible patients in various patient assistance programs. These programs are designed to provide financial relief by offering free or reduced-cost treatments. We strive to ensure that our patients have access to the necessary resources and support, allowing them to focus on their health and well-being without the added stress of financial concerns. Rest assured; we will explore all available options to assist you in managing your healthcare expenses.

## AUTHORIZATION AND ATTESTATION FOR FINANCIAL ASSISTANCE

I understand that **WVCI** and its affiliates (including *The US Oncology Network and Annexus Health*) are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment. In order for **WVCI** and its affiliates to provide me with financial assistance, I understand that they will need to obtain, review, use, and/or disclose my personal health information (PHI), information relating to my medical condition, and information that I otherwise provide to **WVCI** and its affiliates, including my name, address, and other personal identifying information.

I authorize **WVCI** to use my personal health information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I also authorize my physician, pharmacy, insurance companies, and health plan(s) to disclose my personal health information to **WVCI** and its affiliates as necessary to complete applications on my behalf or to verify information on my application.

I understand that my physician and **WVCI** do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers (“Programs”) and is contingent upon the eligibility criteria set forth by the program. I understand that the charitable foundations and product manufacturers (“Programs”) may perform a “soft credit check” to obtain confirmation of household reported income.

By authorizing **WVCI** to submit my application, I attest that I understand and agree to the below statements.

- I understand **WVCI** and/or their affiliates may contact me to obtain any additional information needed to complete an application.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I may provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- I understand that all assistance from Programs is subject to availability of funds at the time funds are requested and that this Authorization is not a guarantee that I will receive or obtain any financial assistance.
- I agree that all information I provide to **WVCI** and applicable Programs, to the best of my knowledge, is true, accurate, and complete, and I will notify **WVCI** and any relevant Program of any changes to the information I provide.
- I agree and authorize **WVCI** and the Assistance Program Sponsor(s) to disclose, obtain, and discuss my medical, treatment, therapy, financial, and other personal information relating to my application with my providers, pharmacy, insurance company, and other organizations working on my behalf to obtain eligible treatment.
- I understand that my protected health information disclosed to **WVCI**, to a Program, or under an applicable application for my financial assistance may be re-disclosed by recipients of my health

Patient Initials_____

information for the purposes described in this Authorization and may no longer be protected by privacy laws, such as HIPAA.

- I understand that if I have applied for assistance elsewhere, I must disclose this to any other Foundation or Patient Assistance Program that approves me for funds or drug product.
- I understand that there is no fee or charge for this support service.
- I understand that the Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me. The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat or cover only certain conditions. Should additional assistance be needed for continuity of treatment, I understand that **WVCI** will complete and submit applications to secondary Programs or submit renewal applications on my behalf.
- I understand and acknowledge that if I do not sign or provide this Authorization, my physician or **WVCI** cannot withhold or condition my healthcare or treatment based on my decision to not sign or provide this Authorization.
- I understand that this authorization is valid for 12 months. I (or my legally authorized representative) may cancel this Authorization at any time by mailing a written request for such cancellation to **WVCI**. However, I understand that any cancellation will not apply to any information already used or disclosed pursuant to this Authorization. I understand that I may request a copy of this Authorization once it has been signed.
- If applicable, I consent to the use of electronic signatures to complete, sign, and deliver this Authorization and agree that my electronic signature is as valid as if I signed the document in writing.

Patient Name (*print*): _____

Patient DOB: _____

**PLEASE SIGN ONE OF THE SECTIONS BELOW**

**I agree and certify that I have read, understood, and will abide by the above attestation and authorize Willamette Valley Cancer Institute and Research Center to proceed with applying for assistance on my behalf.**

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____

**I choose to decline and/or retract my authorization for Willamette Valley Cancer Institute and Research Center and the above listed affiliates to proceed with applying for assistance on my behalf.**

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____