Libby's Legacy Breast Cancer Foundation
112 Annie St., Orlando, FL 32806
Phone: 407.898.1991 ▪ Fax: 407.431.0102
info@libbyslegacy.org ▪ www.libbyslegacy.org

Application for Patient Advocate Liaison Services

LLBCF uses the following information to help determine need for free services. All information is kept confidential, unless otherwise stated.

Date: _____ Name: _____

DOB: _____ /_____ /_____ Age: _____

Please check your status: Citizen _____ Resident _____ Visa _____ Undocumented _____

Address: _____ Zip code: _____ County: _____

Home Ph _____/_____ Cell Ph _____/_____ Work Ph _____/_____

Best # to call: Home / Cell / Work Best time to call: Morning / Afternoon / Evening

Email address: _____ Do you have access to computer? Y/N

Preferred method of contact: Email / phone call / letter

Ethnicity/Race: _____ How do you identify?*(select one)* _____Lesbian _____Gay _____Bisexual _____Transgender_____Heterosexual

Who referred you to us today? _____

Have you ever used Libby's Legacy for breast health services? Y/N

Are you currently employed? Y/N Do you work: part-time / full-time

If yes, who is your employer? _____

If you are not working, why? _____ Year last worked_____

Do you have insurance? Y/N Name of insurance: _____ ID #: _____

Oncologist: _____
Dr. address/ph: _____

Treatment facility: _____
Facility address/ ph: _____

Date of diagnosis: _____ Diagnosis: _____ Stage: _____

Are you currently undergoing any treatments? _____ Yes _____ No

If yes, please explain (include name, number of days per week, and frequency):
_____

Date treatment began or will begin: _____

Do you currently have a support system through either family or friends? Y/N

If you do have a support system, please describe: _____
_____

What services do you need:
_____ Advocacy for treatment
_____ Representative to attend appointments/treatment sessions
_____ Information about resources

Your Emergency Contact : _____ Relationship: _____
Phone: ____/_____

Patient's Statement of Understanding

I have read and understand the above and declare the information furnished by me is true and complete to the best of my knowledge. I consent to the exchange of information between Libby's Legacy Breast Cancer Foundation and other community agencies to provide needed services.

_____
Signature of Patient / Responsible Party

_____
Date

I hereby authorize Libby's Legacy Breast Cancer Foundation to disclose appropriate medical information regarding my care to my referring agency, (agency name) _____ .

_____
Patient / Responsible Party

_____
Date

Filled out by LLBCF Staff: _____ Via: Phone / Walk-in Date_____
Application received by _____ Via: FAX / MAIL / Walk-in / Email Date _____
Reviewed by_____ Date_____