

# MIMA FOUNDATION

## Patient Assistance Program

Please complete each section to the best of your ability.  
If an item does not apply just write N/A in the space  
provided. Return the completed enrollment form to:

MIMA Foundation Patient Assistance Program  
Attn: Jane Lyons, LCSW  
200 East Sheridan Road  
Melbourne, FL 32901  
(321) 725-4500 ext. 747  
Fax (321) 951-9138

### Patient Information

Patient Name: \_\_\_\_\_  
SS#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_  
Work: (\_\_\_\_) \_\_\_\_\_  
Best time to call? \_\_\_\_\_

### Physician Information

Physician Name: \_\_\_\_\_  
Site/ Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Best time to call? \_\_\_\_\_  
State License #: \_\_\_\_\_

### Patient Diagnosis Information

Patient Diagnosis/ICD-9 Code: \_\_\_\_\_

### Physician Declaration

I verify that the patient and physician information  
contained in this enrollment form is complete and  
accurate to the best of my knowledge. I also certify that  
this patient is currently receiving treatment for the  
above mentioned diagnosis.

Physician Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

### Patient Financial Information

Current annual household income: \$ \_\_\_\_\_  
Number of household members dependent on income  
stated above (include applicant) \_\_\_\_\_  
Source of Income:  
Job Family Public Assistance SSI/SSDI  
Other (please explain): \_\_\_\_\_  
\* Income documentation may be required in order to  
assess Patient Assistance Program eligibility.

### Letter of Support

I, \_\_\_\_\_, provide room and board  
and/or financial assistance for \_\_\_\_\_  
Signed \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Date: \_\_\_\_\_

### Request for Assistance

Grants are a one time gift only.  
Please indicate amount of grant requested: \_\_\_\_\_  
Reason for Grant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Patient Declaration

I verify that the information provided in this enrollment  
form for is current, complete, and accurate. I further  
understand the MIMA Foundation may request  
documentation to verify financial information. I  
understand that any assistance in the form of a grant is  
contingent upon my ability to meet eligibility criteria for  
the program.

Patient Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

For Questions concerning the MIMA Foundation  
Patient Assistance Program please contact:

Jane Lyons, LCSW (321) 725-4500 ext. 747  
Oncology Case Manager  
Or  
Paul Kolarik, MA (321) 725-4500 ext. 301  
Oncology Case Manager