

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: Paul Kolarik, MA
1130 Hickory Street
Melbourne, FL 32901
(321) 725-4500 ext. 7301
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:*

**Paul Kolarik, MA (321) 725-4500 ext. 7301
Oncology Case Manager**