Prosthetic Assistance Program (PAP)
Confidential Questionnaire & Application Form

Please complete the below in its entirety and mail to: **OMF PAP 17950 Canby Road Leesburg, Virginia 20175**
OR, you can scan and email along with evidence of income to: **PAP@ocularmelanoma.org**

*All information submitted will remain **100% confidential**. All decisions on the amount, method and other details of any PAP funds disbursement are at the sole discretion of the Ocular Melanoma Foundation (OMF). OMF does not discriminate on the basis of gender, race, culture or language.*

PERSONAL BACKGROUND		
*Please enter personal details on the **patient only**.*		
Date Applied		
Last Name	First	Middle Initial
Street Address		Apartment/Unit #
City	State	ZIP
Phone	E-mail Address	
What is the best method to get in touch with you for follow-up?	Phone / Email / Other	
Gender	Year of Birth	
Number of children	Marital Status	
Have you applied to the OMF for any assistance before (TAG or PAP)?	Yes / No	

MEDICAL BACKGROUND	
*Please provide details on your disease. All information will remain **100% confidential**.*	
Date of diagnosis:	Place of diagnosis:
Hospital/center:	Doctor(s):
Size of primary tumor:	Other features:
Date enucleation performed?	
Do you have an ocular prosthesis now?	Yes / No
If yes, location/extent/cost:	
Other related issues:	

Ophthalmologist or Other Primary Treatment Provider	
Name:	Hospital affiliation:
Address:	City/State/Zip:
Phone:	Email:
Oncologist or Other Secondary Treatment Provider	
Name:	Hospital affiliation:
Address:	City/State/Zip:
Phone:	Email:
General nature of treatment:	

Please describe your full treatment history including dates and locations, with special note of visits to ocularists, estimates of prosthesis costs, etc.

INSURANCE INFORMATION
Do you currently have health insurance?
Type of insurance:
Provider:
Are prescription drugs covered?:
List key OM treatment(s) covered:
Additional comments:

ASSISTANCE SOUGHT
How much have you spent to date on OM-related, doctor-prescribed prostheses?
How much do you plan to spend in the future on OM-related, doctor-prescribed prostheses?
How much assistance are you seeking from the OMF PAP program?

HOUSEHOLD FINANCIAL INFORMATION	
Current Occupation (or list Unemployed):	
Is the patient the primary income source?	
Number of dependents:	
Other family income source(s) (spouse, social security, etc.):	
Total annual family income (AGI as reported to IRS):	
Are their details of your financial situation that we should be aware of? For instance, has your disease forced you to take early retirement or lost you your job?	
Are you currently receiving disability income?	*If yes, list monthly amount.*
Approximate total expense to date from OM treatment:	
Of this amount, what has been out of pocket?	
Please indicate below what form of income verification you will be submitting to OMF.	• The first two pages of signed income tax return (you may black out your social security number) • If you do not file a tax return, you may submit a copy of your most recent pay stub, unemployment check, or SSI, SSD, or public assistance benefit notification • If you do not have any income, provide a letter of support from friend or family member

REQUEST FOR ASSISTANCE
Here, we just want to get to know you better and understand why you are seeking assistance. There is no correct answer and, again, all of your comments will remain 100% confidential.
Why specifically are you applying for prosthetic assistance from OMF?
Is there any additional information you think we should know?

DISCLAIMER AND SIGNATURE
I certify that my answers are true and complete to the best of my knowledge.
Signature _____ Date _____