ADA COUNTY
INDIGENT SERVICES

Office (208) 287-7960
Fax (208) 287-7969
252 E. Front Street, Suite 199
Boise ID 83702

PHYSICIANS NAME: _____ **Service Worker:** _____

CANCER TREATMENT PLAN for Medical Indigency Application Filed on: _____

PATIENT: _____ **DOB:** _____ **SSN:** _____

- **Diagnosis:** _____
- **Describe all medical services, for up to 6 months, in the format below. Include information about planned or potential services related to this condition. Be as specific as possible. ATTACH CHART NOTES, AND RELATED DIAGNOSTIC REPORTS**

☐ **Radiation:**

PROVIDER		DATES OF SERVICE		PROCEDURE CODE
Wks of XRT	# Boosts		Site of XRT	Total Estimated Cost
		☐ Simple ☐ Intermediate ☐ Complex		
		☐ Simple ☐ Intermediate ☐ Complex		

☐ **Chemotherapy:**

PROVIDER		DATES OF SERVICE		PROCEDURE CODE
Name of Medicines	Dosage in mg	Cost per dose	# Doses	Total Estimated Cost

☐ **Diagnostics (Medical Imaging, Pathology/Labs, Biopsies):**

PROCEDURE/TEST	PROVIDER	DATES OR # OF TESTS	PROCEDURE CODE	ESTIMATED COST

☐ **Other Anticipated Treatment (Surgeries, Nursing, Infusion, Supplies):**

DOCTOR VISITS	PROVIDER	DATES OR # OF VISITS	PROCEDURE CODE	ESTIMATED COST

- Were/are the medical services ☐ emergency or ☐ non-emergency?
- Can non-emergency services wait for ten days from the **date of application**? Yes ☐ No ☐
- Release date for employment: _____ list any restrictions _____
- Will Patient be able to return to present occupation? Yes ☐ No ☐
- If not, is patient disabled for next 12 months and a candidate for Social Security Disability? Yes ☐ No ☐

Additional comments, including prognosis: (Attach additional sheets if needed.)

_____

_____

_____ _____ _____

Physician's Signature **Date** **Telephone**