Patient Enrollment Application

Welcome to Good Days, a non-profit organization whose financial assistance programs provide thousands of individuals diagnosed with life-altering diseases the opportunity to get the medications they need to help improve their quality of life.

In order for us to begin the process of qualifying you for financial assistance, please complete the enclosed application and return it to Good Days, along with copies of your insurance card(s). Completed applications can be received via mail or fax.

Upon receipt of your completed application, Good Days will determine if you are eligible for financial assistance based on our Program Guidelines and subject to available funding. To verify household size and household income Good Days will perform a soft inquiry with a third party vendor in order to determine eligibility. This inquiry can only be viewed by you (the patient) on your credit history and will not affect your credit score. We will advise you and/or your medication provider of the final outcome.

If you qualify and if funding is available, we will provide you with financial assistance for the remainder of the calendar year. We will also provide you with a username and password so that you may freely access our therapy management portal found at https://patientsandpros.MyGoodDays.org

Please understand that all approvals are based on available funding and are approved on a first-come, first-served basis. **Receipt of application does not guarantee funding**

Please call us toll-free at (877) 968-7233 if you have any questions or need assistance filling out the following enrollment forms.

Sincerely,

Good Days,
A Non-Profit Organization

Required Documentation & Submission Options

Documentation Required

1. Pages 3-5 signed and dated where applicable along with copies household income documentation.

2. A copy of the front and back of the patient's insurance cards

3. Income Verification: Good Days and its authorized third party agents will use your demographic information, including but not limited to, Social Security Number, Date of Birth, Name, and/or Address as needed to access your credit information and information derived from public and other sources to estimate your income in conjunction with the eligibility determination process. As a soft credit inquiry, this does not impact your credit score. Good Days and its authorized third party agents reserve the right to ask for additional documents and information at any time.

Submission Options

1. FAX: (214) 570-3621

2. MAIL: Good Days
   Attn: Enrollment
   2611 Internet Blvd, Suite 105
   Frisco, TX 75034

Please review enrollment information below. Complete form by filling in missing information. Make any corrections by writing changes next to the information provided.

Date:	How much can you afford for this medication? *You may be responsible for any remaining balance Good Days does not cover.*
ID or SSN:	

PATIENT INFORMATION

Patient's Name:	Birth Date:
Alternate Contact:	Relationship:
Mailing Address:	Home phone:
	Cell Phone:
	Work Phone: Ext:
E-mail Address:	

INCOME INFORMATION

Annual Household Income:	Number of people in household:

PHYSICIAN INFORMATION

Physician Name:	Physician Phone:
Office Address: (*if known*)	Physician NPI:

DIAGNOSIS INFORMATION

Diagnosis:	
Medication:	
Pharmacy:	Pharmacy Address or Phone: (*if known*)

MAJOR MEDICAL INSURANCE INFORMATION

Insurance Name:		
ID#:	Group #:	Phone:

DRUG CARD INFORMATION

Insurance Name:	ID#	
BIN:	PCN:	Phone:

Is this a Medicare, Federal or State funded insurance plan?

Yes No *(circle applicable answer)*

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*Metastatic Cancer Diagnoses Only

For patients in a metastatic cancer fund: If your physician has prescribed a drug to treat your metastatic cancer that is not on Good Days' formulary, please contact us. We may be able to cover the prescribed drug if we receive additional documentation showing that the drug otherwise meets our criteria. For our metastatic cancer funds, Good Days will cover all drugs approved by the Food and Drug Administration (the "FDA") that treat the type of cancer that is the basis of the disease fund into which you have been accepted. For example, if you have metastatic breast cancer, Good Days will cover all drugs that are approved by the FDA to treat breast cancer, not just those drugs that the FDA has expressly approved for the metastatic stage of breast cancer.

Declaration

You attest and certify to Good Days and its agents that the information provided in your application is complete and accurate. You understand that, and consent to, your reported financial information being verified by an audit as deemed necessary by Good Days. Good Days, and its authorized third party agents, such as credit monitoring companies, may use your demographic information, including but not limited to your social security number, date of birth, name, and address in order to estimate your income in conjunction with the eligibility process. You understand that Good Days, and its authorized third party agents, reserve the right to ask for additional documents and information at any time. As a soft credit inquiry, this does not impact your credit score.

You further understand that any false or incomplete information provided by you to Good Days could unduly harm your application process, Good Days, its reputation, and its tax exempt status. You also understand that any financial assistance provided to you by Good Days may be recouped, if Good Days becomes aware of any inaccurate information or fraudulent activity relating to your application or the assistance provided to you. You understand that you are free at any time to switch providers, practitioners, suppliers, or treatments within the Good Days formulary for your diagnosis without affecting your continued eligibility for assistance.

You understand that you are not guaranteed or promised assistance. Any assistance Good Days may provide is limited to the terms and conditions established by Good Days. Good Days reserves the right at any time, and for any reason without notice, to modify the eligibility criteria or modify or discontinue any assistance.

Limitation of Liability:

You agree that Good Days, our sponsors, and our donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-pay relief, or other value-added benefits or services provided as a part of this program.

Patient Attestation:

You agree to be fully compliant in taking the drug for which financial assistance is being provided in accordance with your doctor's directions.

By signing below you agree that you have read, understand and agree to adhere to the above statements

Signature of Individual or Individual's representative	Date
Print name of Individual's representative: (If applicable)	Authorized Relationship or Authority to Act (If applicable)

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2611 Internet Blvd, Suite 105 Frisco, TX 75034
877-968-7233 ● Fax 214-570-3621 ● www.mygooddays.org
Private and Confidential when completed

Terms of the Consent Pertaining to the Disclosure of your Personal Information

In order for you to receive assistance through Good Days, you authorize your physicians, pharmacies and insurance companies to disclose to Good Days and its applicable contractors, employees, agents and other representatives your personal information. In addition you authorize Good Days to use and disclose your personal information to Good Days' agents, third parties acting on its behalf, credit monitoring companies, or any of your healthcare providers.

Your personal information may include, but not be limited to, your name, address, phone number, email address, date of birth, social security number, insurance status and numbers, amount of financial assistance allocated and dispensed, diagnosis information, and treatment information.

You consent to the disclosure of your personal information for the following purposes: (i) to enable Good Days to determine whether you are eligible and qualify for financial assistance for any medication(s); (ii) to enable Good Days to provide financial assistance to you for your medication(s); (iii) to refer you to, or to determine your eligibility for, other programs, foundations or alternate sources of funding or coverage for your healthcare costs, products and services; (iv) to facilitate the audit or review of Good Days' operations; and (v) to enable Good Days to manage its patient assistance programs.

You understand that your personal information that is disclosed may be re-disclosed by the recipient and no longer protected by federal or state privacy regulations and laws. You consent to Good Days re-validating your personal information. You consent to Good Days electronically disclosing your personal information to third parties as permitted or required by law.

You may revoke this consent at any time by mailing a signed letter of revocation to Good Days' Privacy Officer at 2611 Internet Blvd, Suite 105 Frisco, TX 75034 or faxing the written consent to Good Days' Privacy Officer at the following fax number: (214) 570-3636. Revoking this consent will not have any effect on actions that Good Days took in reliance on the consent before it received notice of your revocation. If you revoke this consent, you will not be able to receive future assistance through Good Days. However, your applicable healthcare providers and insurance companies, who are disclosing the information to Good Days, may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this consent.

This consent expires six years from the date that you last receive assistance from Good Days, if not revoked sooner.

Signature of Individual or Individual's representative	Date
Print name of Individual's representative: (If applicable)	Authorized Relationship or Authority to Act (If applicable)

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PLEASE VISIT WWW.MYGOODDAYS.ORG/APPLY TO PRINT A COPY OF THE CONSENT