



Christopher D. Rich
Clerk of the District Court

Phil McGrane
Chief Deputy

252 E Front St, Ste 199, Boise, Idaho 83702 Phone (208) 287-7960 Fax (208) 287-7969

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
		<input type="checkbox"/> Simple <input type="checkbox"/> Intermediate <input type="checkbox"/> Complex			
		<input type="checkbox"/> Simple <input type="checkbox"/> Intermediate <input type="checkbox"/> 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.)

