



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 email, 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

2611 Internet Blvd, Suite 105, Frisco, TX 75034
877-968-7233 • Fax 214-570-3621 • www.mygooddays.org

Private and Confidential when completed

Required Documentation & Submission Options

Documentation Required

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

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.

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

Submission Options

1. EMAIL: admin@mygooddays.org
2. FAX: (214) 570-3621
3. MAIL: Good Days
Attn: Enrollment
2611 Internet Blvd, Suite 105
Frisco, TX 75034

*Would you like to receive an immediate determination of eligibility?
Scan the QR code to be directed to the online application.*



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All fields with an asterisk (*) are required.

GOOD DAYS PATIENT ENROLLMENT APPLICATION		Page 3 of 5
PATIENT INFORMATION		
*Name:	*Date of Birth: / /	
*SSN:	*Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
<i>Providing a partial or incorrect SSN may result in application delays.</i>		
*Mailing Address:		
*Phone:	Is this a mobile number? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Email:		
<i>If the program you are applying for is closed, your email will automatically be added to the notification list to be notified if it reopens.</i>		
ALTERNATE CONTACT INFORMATION		
Name:	Relationship:	
Phone:	Is this a mobile number? Yes <input type="checkbox"/> No <input type="checkbox"/>	
INCOME INFORMATION		
*Annual Household Income: \$	*Number of People in Household:	
PHYSICIAN INFORMATION		
*Provider Name:	*Phone:	
Office Address: <i>(if known)</i>	NPI: <i>(if known)</i>	
DIAGNOSIS INFORMATION		
*Diagnosis:	*Medication(s):	
PHARMACY INFORMATION		
*Pharmacy Name:	Phone: <i>(if known)</i>	
Pharmacy Address: <i>(if known)</i>		

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GOOD DAYS PATIENT ENROLLMENT APPLICATION			Page 4 of 5
PRIMARY INSURANCE INFORMATION			
*Insurance Name:		*Member ID:	
BIN:	PCN:	*Phone:	
*Is this a Medicare, Military or Federal Employee insurance plan?			Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Proof of Insurance may be required for patients under the age of 65 with a Medicare, Military or Federal Employee insurance plan.</i>			

SECONDARY INSURANCE INFORMATION			
Insurance Name:		Member ID:	
BIN:	PCN:	Phone:	
Is this a Medicare, Military or Federal Employee insurance plan?			Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Proof of Insurance may be required for patients under the age of 65 with a Medicare, Military or Federal Employee insurance plan.</i>			
REFERRAL INFORMATION (if applicable)			
Organization Name:		ID:	
How did you hear about us?	Web Search <input type="checkbox"/>	Social Media <input type="checkbox"/>	Provider <input type="checkbox"/>
	Pharmacy <input type="checkbox"/>	Other <input type="checkbox"/> _____	

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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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