

Pennsylvania Tobacco Grant Fund



REQUEST FOR TOBACCO QUIT PRODUCTS ASSISTANCE

Under the guidelines set by the Pennsylvania Department of Health, we are able to provide Tobacco Quit Products (as funding permits) for uninsured and/or underinsured people over the age of 18.

Somerset County

Date _____

Patient Name _____ Birth Date _____

Street Address _____

City, State, Zip _____

Phone Number _____ Physician _____

Do you have medical insurance that does not cover the cost of TOBACCO QUIT PRODUCTS? **Y N**

I hereby certify that the above information is true and correct. I authorize this agent to obtain the necessary information to verify and evaluate this request. I will notify this agent of any changes in the information included in this application.

I also certify that I am enrolled in/participating in the following smoking cessation program:

___ PA Quitline

___ Cessation Program

Location of Program _____

Program Facilitator _____

Program Start Date _____

Disclaimer: In consideration for being allowed to register and participate in the PA Department of Health's Tobacco Quit Product's Program, I hereby release this agent, its physicians, board members, officers, employees, contractors and volunteer workers from any liability for complications, side effects which are sustained as a result of the products or smoking cessation initiatives. I understand that any medical treatment recommended by medical personnel as a result of my participation in this program will be at my expense.

Applicant Signature : _____

PROVIDER USE ONLY - TOBACCO QUIT PRODUCTS : _____

If taking a cessation class at the hospital, please bring this completed form with your prescription to the first session. If you are using the Quitline, please either drop off or mail the completed form to Somerset Hospital, Attn: Melissa Wojtaszek, Tobacco Cessation Coordinator, 225 South Center Avenue, Somerset, PA 15501.