

Finding and applying for a TotalAssist grant

Applying for a TotalAssist grant

1

Pre-screen

Making sure you meet the requirements for the fund

2

Patient information

Demographic information, applicant information

3

Authorized person(s)

Approved persons to speak about grant (if applicable)



You will find out instantly if you have been approved, in most cases. If approved, you can begin using your TotalAssist grant right away.

4

Insurance

Medical insurance details

5

Medical

Treating provider and diagnosis information

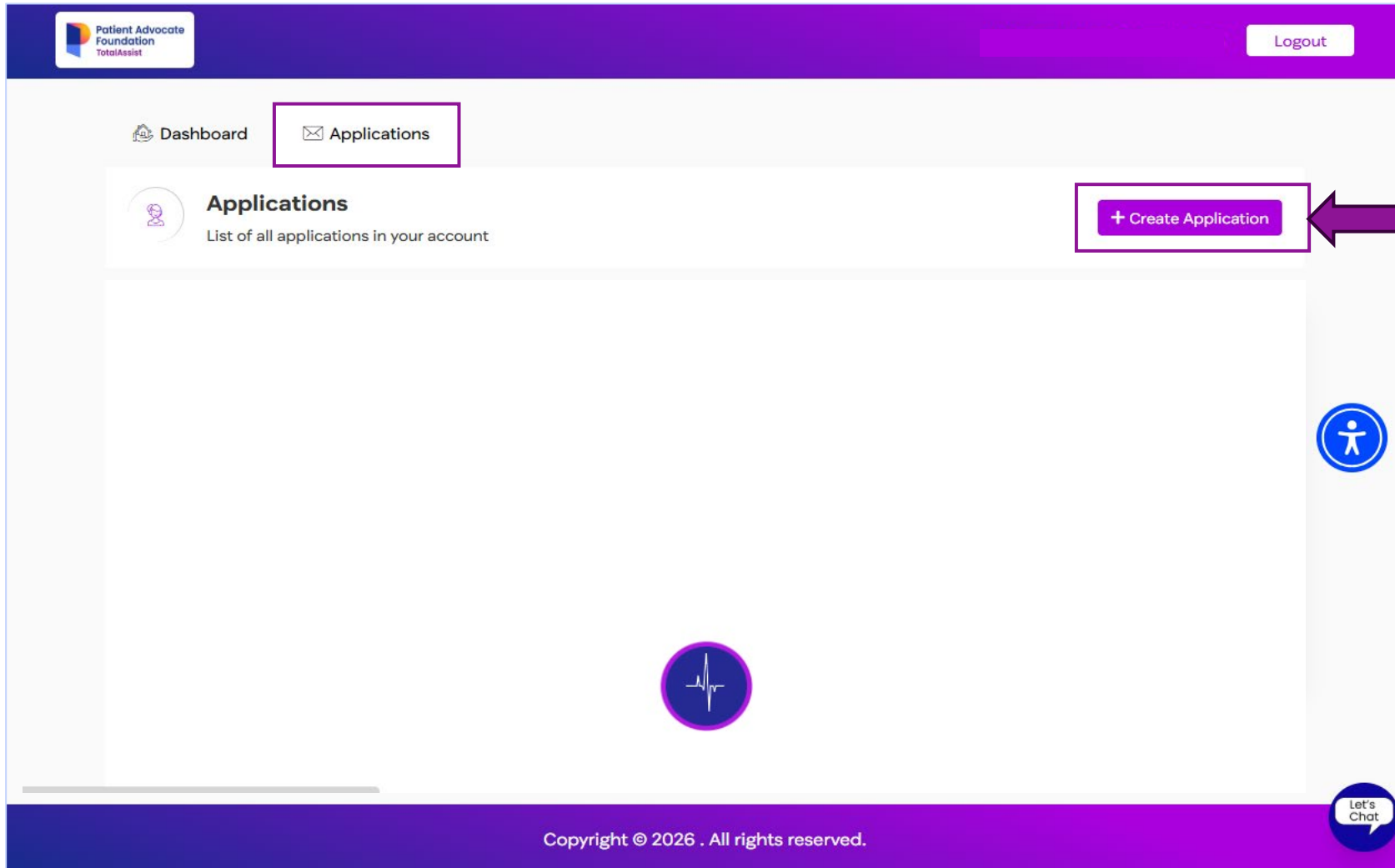
6

Authorization

Terms and conditions, attestation



Starting the application



Select the **'Applications'** tab, then click the **'+Create Application'** button to begin.

Step 1. Begin Pre-Screen

The screenshot shows a web application interface for the Patient Advocate Foundation TotalAssist. At the top, there is a purple header with the logo on the left and a 'Logout' button on the right. Below the header, there are navigation tabs for 'Dashboard' and 'Applications'. The main content area is titled 'CREATE APPLICATION' with a 'Cancel' button. The central form is titled 'TOTALASSIST PROGRAM APPLICATION' and displays the user's name 'Juanita Rivera', a phone number 'xxx-xx-3897', and a date '01/13/1952'. Below this is a 'PRE SCREEN' section with several input fields: 'Address Line 1' (421 Butler Farm Rd), 'Address Line 2', 'City' (Hampton), 'State' (Virginia), and 'ZIP Code' (23666). A 'VERIFY ADDRESS' button is highlighted with a red box and a red arrow pointing to it from the right. At the bottom of the page, there is a purple footer with the text 'Copyright © 2026 . All rights reserved.'

Your address should already be displayed. Make changes if needed, then click **‘Verify address’**.

Step 1. Pre-screen - continued

Patient Advocate Foundation
TotalAssist

Logout

Dashboard

CREAT

Address

We could not verify the information provided. Please confirm the address entered is accurate.

Address-Provided

421 Butler Farm Rd,
Hampton, VA
23666

KEEP UNVERIFIED ADDRESS

Cancel

Address Line 1
421 Butler Farm Rd

Address Line 2

City
Hampton

State
Virginia

ZIP Code
23666

VERIFY ADDRESS

The system will attempt to match the address with all known postal addresses.

If unable to verify (as shown), please check for errors, then click **'Keep Verified Address'** and proceed if correct.

Step 1. Pre-screen - continued

CREATE APPLICATION Cancel

TOTALASSIST PROGRAM APPLICATION
Juanita Rivera | xxx-xx-3897 | 01/13/1952

PRE SCREEN

Address Line 1
421 Butler Farm Rd

Address Line 2
Address Line 2

City
Hampton

State
Virginia

ZIP Code
23666

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

VERIFY ADDRESS

Patient's Diagnosis
Breast Cancer

Does the patient have medical and/or prescription insurance
Yes

Insurance Type
Medicaid

Fund Applying For
Breast Cancer

Next

Select your diagnosis from the drop down.

Answer insurance questions.

Select the TotalAssist fund you are applying for, then click **'Next'**.

Step 1. Pre-screen – continued

The screenshot shows a web interface for the Patient Advocate Foundation TotalAssist. A modal dialog is open, displaying the following information:

- Patient Name:** Juanita Rivera
- Address:** 421 Butler Farm Rd, Hampton, VA, 23666


At the bottom of the modal are two buttons: **CONTINUE EDITING** and **CONFIRM**. A purple arrow points from a text box on the right towards the **CONFIRM** button. Below the modal, the main form is partially visible, showing a 'PRE SCREEN' section with the following fields:

- Address Line 1:** 421 Butler Farm Rd
- Address Line 2:** (empty)
- City:** Hampton
- State:** Virginia
- ZIP Code:** 23666

Below these fields is a message: "Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed." and a **VERIFY ADDRESS** button. At the bottom of the form, there are dropdown menus for **Patient's Diagnosis** (Breast Cancer) and **Insurance Type** (Medicaid).

'Confirm' or 'Continue editing' your address before proceeding.

Step 1. Pre-screen – continued

 CREATE APPLICATION [Cancel](#)

TOTALASSIST PROGRAM APPLICATION
Juanita Rivera | xxx-xx-3897 | 01/13/1952

PRE QUALIFICATION


Is the patient currently in treatment, planning to begin treatment in the next 60 days or have been in treatment in the past 6 months? select ▼


Does the patient have medical or prescription insurance that covers a portion of their pharmaceutical products being prescribed for their diagnosis? select ▼

Is the patient a legal resident of the US, residing in the US or a US territory? select ▼

If you could rate the impact of this grant, if approved what would it be (10 being High Impact 1 being Little to No Impact)? select ▼

[Next](#)





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Answer pre-qualification questions, then click **'Next'** to complete the pre-screen.

Step 1. Pre-screen – complete

CREATE APPLICATION

Prequalification successful!

TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Fund Applied for: Breast Cancer

ADDRESS DETAILS

Address Type	Address Line 1	Address Line 2
Home	400 Myrtle St	
City	State	ZipCode
Fairhope	AL	36532

CONTACT DETAILS

How would the Patient like to be contacted? All program letters and communications will be sent to the patient based on your selection.

Preferred Contact Method

Preferred Language

Email

Email Type

Let's Chat

After completing the pre-screen, you will receive an on-screen pop-up notification.

The notification will be green if prequalification was successful, and red if not successful.

If green, continue to patient information section.

Your address details will pre-populate.

Patient data is fictional.

Step 2: Patient information

CONTACT DETAILS

How would you like to be contacted? All program letters and communications will be sent to you based on your selection.

Preferred Language English	Email brittany.winfree@gmail.com	Preferred Contact Method Mail
Email Owner Caregiver	Phone Type Cell	Email Type Other
	Phone Number 555-555-5555	

ADDITIONAL INFORMATION

Gender Female	Employment Status Retired	Veteran No
Marital Status Widowed	Household Size 1	

Race (Select all that applies)

<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input checked="" type="checkbox"/> Black/African American
<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Prefer not to disclose
<input type="checkbox"/> Other	<input type="checkbox"/> Race Test	<input type="checkbox"/> TEST

Hispanic/Latino/Spanish Origin?
No

Do you receive assistance from other Co-Pay Programs? NO

Scroll down and complete sections for **‘Contact details’** and **‘Additional information’**.



Step 2. Patient information – continued

APPLICANT INFORMATION

Relationship to Patient
Self

REFERRAL INFORMATION

How was the patient referred to the program?
Program
Friend

NEXT

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Fill out **'Applicant information'** section (information about the person creating the application).

Complete **'Referral information'** by selecting how the patient learned about the TotalAssist program from the dropdown menu, then click **'Next'**.

Step 3: Authorized person

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Patient information will only be discussed or released as required to assist in the determination and delivery of services from the Program to which the patient is applying. Any requests or sharing of information with anyone other than the medical team, can only be done with the expressed consent of the patient. Please list all individuals (other than patient's medical care team) that the patient has authorized to contact the program on their behalf. (Examples of such individuals can include case managers (not part of the medical care team), spouse, children, friends, etc.).

Are there any authorized users able to speak on behalf of the patient? YES

First Name: Rosemary Last Name: Russell Suffix:
Relationship to Patient: Family
Would the patient like program communications sent to this authorized person via email? YES Email Address: rodney.hughes7@yahoo.com
Same Address as Patient? YES Same Phone Number as Patient? YES
ADD ONE MORE
PREVIOUS NEXT
Let's Chat

Select whether any individuals are authorized to speak on your behalf.

If 'Yes', complete contact information and answer required questions.
Add additional authorized persons as needed, then select 'Next'.

Step 4: Insurance

Dashboard Applications Claims Patient Search

CREATE APPLICATION Cancel

TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

POLICY DETAILS

Primary Insurance: Medicare
Plan Type: Medicare-A+D
Insurance Type: Medicare

INSURANCE INFO

Does the patient have secondary insurance? YES NO

PREVIOUS NEXT

Let's Chat

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Complete section for **'Policy details'** by selecting the primary insurance carrier and plan type from the dropdown menus.

Tip: If you don't find the insurance carrier on the **'Primary insurance'** list, simply type in the insurance carrier name to proceed.

Under **'Insurance info,'** add secondary insurance if applicable, and click **'Next'**.

Patient data is fictional.

Step 5: Medical

TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Provider Diagnosis and Treatment

Search Your Treating Provider

Please enter NPI Number or State and City to search for your treating provider.
Enter additional information to improve your search results.
Press the Tab key to start your search.

NPI Number	State Alabama	City Fairhope
First Name	Last Name	ZIP Code

Select Your Treating Provider

The following providers match your search criteria. Please select your treating provider from the list below by clicking on the appropriate selection. Once you have selected the treating provider it will be highlighted in blue. If you need to make a change in your selection, simply click on the correct provider. If you do not see your treating provider on the list below, [click here to add](#).

First Name ↑↓	Last Name ↑↓	City ↑↓	Address ↑↓	NPI ↑↓
Ansley	Bishop	Fairhope	123 Maple Lane	12345678
Catherine	Dunwoody	Fairhope	456 Main Street	90123456
Earnest	Flores	Fairhope	78 Poplar Ave	78901234
Geraldine	Harris	Fairhope	90 Aspen Cir	56789012

Search for your treating provider by entering information into one or more of the fields in the blue box.

A list of providers matching the criteria you entered will display below. Click on the provider's name to select.

Provider data is fictional.

Step 5: Medical – continued

TOTALASSIST PROGRAM APPLICATION

Application Intake - Treating Physician

ANSLEY BISHOP - 12345678

Other names:

Address Type

SUBMIT **CANCEL**

1 PATIENT

Physician Di

NPI Number State City

First Name Last Name ZIP Code

Select Your Treating Physician

The following physicians match your search criteria. Please select your treating physician from the list below by clicking on the appropriate selection. Once you have selected the treating physician it will be highlighted in blue. If you need to make a change in your selection, simply click on the correct physician. If you do not see your treating physician on the list below, [click here to add](#).

First Name ↑↓	Last Name ↑↓	City ↑↓	Address ↑↓	NPI ↑↓
Ansley	Bishop	Fairhope	123 Maple Lane	12345678

Let's Chat

Select the address type from the dropdown and click **'Submit'**.

Provider data is fictional.

Step 5: Medical – continued

TOTALASSIST PROGRAM APPLICATION

Application Intake - Treating Physician

ANSLEY BISHOP - 12345678

Other names:
Address Type
Physical (123 Maple Lane)

ADDRESS DETAILS

Address Line 1 123 MAPLE LANE	Address Line 2 -
City FAIRHOPE	State AL
Zip Code 36532	

CONTACT DETAILS

Phone Number 555-555-5555	Email Address _____
Fax 333-333-3333	Extension _____

SUBMIT **CANCEL**

Confirm and edit the contact details as needed.

Double-check the listed fax number to ensure the information is correct. The diagnosis verification form will be sent via fax to your treating provider.

When finished, click **'Submit'**.

Provider data is fictional.

Step 5: Medical – continued

TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Search Your Treating Provider

Please enter State and City to search for your treating provider.
Enter additional information to improve your search results.
Press the Tab Key to start your search.

State: Virginia City: Hampton First Name: Last Name: ZIP Code:

Select Your Treating Provider

The following providers match your search criteria. Please select your treating provider from the list below by clicking on the appropriate selection. Once you have selected the treating provider it will be highlighted in blue. If you need to make a change in your selection, simply click on the correct provider. If you do not see your treating provider on the list below, [click here to add](#)

First Name ↑↓	Last Name ↑↓	City ↑↓	Address ↑↓
SHARITA	HOLMES	Hampton	401 E Mercury Blvd
MARY	ADAMS	HAMPTON	3000 COLISEUM DR
ALYSSA	MOSS	HAMPTON	2202 EXECUTIVE DR STE C
DONNA	ABBOTT	HAMPTON	9 MANHATTAN SQ STE B
MICHELLE	WRIGHT	HAMPTON	77 NEALY AVE
EVA	JONES	HAMPTON	16 HOLIDAY DR
JAMAAL	ALLEN	HAMPTON	919 W MERCURY BLVD
MELISSA	ABBAN	HAMPTON	6 NORTHWOOD DR
MARY	GLASHEEN	HAMPTON	DEPARTMENT OF VETERAN AFFAIRS MEDICAL CTR
NATALIE	BARRON	HAMPTON	191 FOX HILL RD

1 2 3 4 5 > >>

Your selection will be **highlighted in blue.**

After confirming contact details for the treating provider, **scroll down the page.**

Step 5: Medical – continued

1 2 3 4 5 > >>

First name SHARITA	Last name HOLMES	NPI Number 1003410135
AddressType Physical	Address Line 1 401 E Mercury Blvd	Address Line 2 -
City Hampton	State VA	Zipcode 23663
Phone Number 757-728-3524	Fax 757-728-3529	

Selected Treating Provider

Patient's Primary Diagnosis
Breast Cancer

Date of Diagnosis
02/06/2026

Patient's Current Medication (Related to Diagnosis)

Please select all medications that the patient is currently taking for this diagnosis. The TotalAssist grant can only be used for co-pays, co-insurance, or deductibles for medications listed here, as well as certain costs related to treatment and medical and prescription insurance premiums.

Patient's Current Medications (Related to Diagnosis)
Doxorubicin Hydrochloride-Doxorubicin Hydrochloride x

PREVIOUS NEXT

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Enter your **date of diagnosis**.

Next, **select the medication(s)** from the dropdown you will be seeking assistance for and click **'Next'**.

If you will not be using your TotalAssist grant for medication-related expenses, select **'Insurance'**.

Step 6: Authorization

Click 'View patient agreement' to review and agree.



TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Patient Agreement, Disclosures, and Attestations:

The patient/authorized agent must review and agree to the Patient Agreement. This gives PAF permission to process the application. Click the View Patient Agreement button below.

VIEW PATIENT AGREEMENT

Opt-In

May the Patient Advocate Foundation and the TotalAssist Program use your contact information in the future to share printed and or electronic communications with you? Application updates will still be sent regardless of your choice.

YES

PRINT PATIENT AGREEMENT

For a complete copy of the PAF TotalAssist program disclaimer and Patient Agreement, Disclosures, & Attestations, please click [here](#)

PREVIOUS **SIGN AND SUBMIT**

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Step 6: Authorization

Review the agreement, disclosures, and attestation, and **click the required check box.**

To complete, **select 'Yes'** to acknowledge that you have read and understand materials and agree to the terms of the program.

Patient Agreement, Disclosures, & Attestations:

I agree that the information provided in this application is truthful and accurate. I agree to notify Patient Advocate Foundation ("PAF") if the financial situation, insurance status, or medical condition changes from what has been documented in this application.

I authorize my health care provider(s)/pharmacy(s) and my insurance company(ies) to disclose to PAF and its employees, third-party administrators, agents, and other representatives (collectively "the Foundation"), information about me, my current medical condition, and my health insurance coverage. The Foundation agrees to treat all such information as confidential.

Patients should only be enrolled in grants that provide financial support with their confirmed medical diagnoses. Enrollment in any fund for which the patient does not meet the specified diagnosis criteria is strictly prohibited. All patient diagnoses are verified as part of the eligibility and enrollment process to ensure compliance with program guidelines. If the diagnosis cannot be verified for any reason, the patient will be disenrolled from the grant(s) immediately. If it is determined that a patient is enrolled in multiple disease specific grants for which they do not have a confirmed diagnosis, they will be disenrolled from those grants and will not be allowed to access support from the program in the future.

I hereby authorize PAF to:

- Use the information provided in the TotalAssist application form including their Social Security Number, to determine their eligibility for, and assist with their continued participation in, TotalAssist.

Use my Social Security Number to access my credit information and information derived from public and other sources to verify my financial eligibility for participation in the program as well as my place of residency as part of the eligibility determination process.

Contact me to seek feedback on TotalAssist services.

Use my contact information in the future to share printed and/or electronic communications from PAF.

Do you acknowledge that you have read and understand the Patient Agreement, Disclosures, & Attestations and agree to the terms of the program?

YES **NO**

Step 6: Authorization – continued

TOTALASSIST PROGRAM APPLICATION

Juanita Rivera | xxx-xx-3897 | 01/13/1952

1 PATIENT INFORMATION 2 AUTHORIZED PERSON 3 INSURANCE 4 MEDICAL 5 AUTHORIZATION

Patient Agreement, Disclosures, and Attestations:

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Opt-In

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YES

PRINT PATIENT AGREEMENT

For a complete copy of the PAF TotalAssist program disclaimer and Patient Agreement, Disclosures, & Attestations, please click [here](#)

PREVIOUS **SIGN AND SUBMIT**

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To complete the application, click 'Sign and submit'.

Application complete: Instant approval decision

The screenshot shows the 'Applications' tab in the Patient Advocate Foundation TotalAssist portal. The application reference number is APPTAA20264041006 for Breast Cancer. A green banner at the top of the main content area reads '✓ CONGRATULATIONS Your Application has been approved'. Below this, there is a congratulatory message and instructions regarding the diagnosis verification form. A virtual pharmacy card is displayed with the following details: Patient Name: JUANITA RIVERA, Eligibility Period: 12/21/2025 - 06/19/2027, Card Holder: 1000544964, BIN: 610020, PCN: PXXPDMI, and Group: 99999999. Contact information for pharmacy and patient inquiries is also provided. A link to the 'TotalAssist Claim Guide' is visible at the bottom of the main content area. The footer contains the copyright notice: Copyright © 2026. All rights reserved.

After submitting the application, you will be automatically taken to the **'Applications'** tab.

You will receive an **instant approval decision** (in most cases).

If approved, you can scroll down to view the **virtual pharmacy card**. You will use this at pharmacies or specialty pharmacies.

This page also contains a link to download the **TotalAssist Claim Guide**.

Application information – full details

All **application information** can be found here.

You can also upload documents, review correspondence, view and submit claims, and access the pharmacy card from this view.



The screenshot displays the 'Applications' page in the Patient Advocate Foundation TotalAssist system. The header includes the logo and a 'Logout' button. The main content area shows the application details for 'Breast Cancer' with the reference number 'APPTAA20264041006'. A sidebar menu on the left lists various options: Award Info, Patient Info, Authorized Person, Insurance Details, Physician/Diagnosis, Upload Documents, Correspondence, Claims, and Application Status / Pharmacy Card. The 'Award Info' section is expanded, showing a table of details and a balance of \$6500.00. A green 'APPROVED' button is visible in the top right of the award info section.

AWARD INFO		
Fund Applied for : Breast Cancer	Effective Date : June 19, 2026	Expiry Date : June 19, 2027
Award Year : 2026	Revoke Date : October 17, 2026	LookbackDate : December 21, 2025
Balance : \$ 6500.00		

Patient Dashboard

Click on the **‘Dashboard’** tab after reviewing your application details to return to the home screen.

Your most recent application and grant details will be displayed under **‘Recently Created Application’** and listed under **‘Recent Activities’**.

Under **‘Actions Required,’** you will see any needed actions to complete.

Dashboard Applications

Patient Dashboard
List of all the Action Items

Recently Created Application

BREAST CANCER **Approved**

JUANITA RIVERA

AWARD YEAR	BALANCE
2026	\$6,500.00

EFF Date: Jun 19, 2026

Expiry Date: Jun 19, 2027

LookBack Date: Dec 21, 2025

[View Application Details →](#)

Recent Activities

JUANITA RIVERA
App ref APPTAA20264041006 is
Application Approved
[View Details](#)

[View All >>](#)

Actions Required

Ref	Patient	Actions
Awaiting Diagnosis Verification	JUANITA RIVERA	Complete Action

[View All >>](#)

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