



What is Financial Assistance from CancerCare?

- ❶ CancerCare provides limited financial assistance to help with the costs of treatment-related transportation, child care, and home care, for all types of cancer.
- ❶ CancerCare’s financial assistance does not cover basic living expenses such as rent, mortgages, utility payments, or food.

Who is eligible?

In order to be eligible for financial assistance you must:

- Have a diagnosis of cancer as certified by an oncology healthcare provider
- Be in active treatment for your cancer

Meet our financial eligibility guidelines of 250% of the Federal Poverty Limits AND provide proof of income. Acceptable proof of income include:

Household Size	Gross Family Income	Acceptable Proof of Income
1	\$27,925	<ul style="list-style-type: none"> • The first two pages of signed copy of income tax return. (You may blacken out your social security number) <li style="text-align: center;">- OR - • If you do not file a tax return: Copies of your most recent pay stub, unemployment check, or SSI, SSD, or public assistance benefit notification <li style="text-align: center;">- OR - • If you do not have income: Provide a letter of support from friend or family member
2	\$37,825	
3	\$47,725	
4	\$57,625	

How do I apply?

There are 3 steps which **MUST BE COMPLETED** in order for an application to be considered.

1. You MUST first speak with a CancerCare social worker to complete a brief interview. Call our Hopeline at **800-813-HOPE (4673)**

- Hours of operation: 9 a.m. – 7 p.m. Eastern Time, Monday – Thursday; and 9 a.m. – 5 p.m. Eastern Time, Friday.

2. If you are eligible for financial assistance, we will send you an individualized bar coded application.

3. You MUST submit a completed financial assistance application.

- **Please PRINT clearly, as illegible applications cannot be processed.**
- Please fill in each blank space in the application. Use ‘no’, ‘none’, or ‘0’ as appropriate; do not leave a blank response.
- A medical **oncology professional must complete all sections of the Medical Information Section and provide a signature and date.** You or your family member cannot complete this section!
- Note the correct CancerCare mailing address and fax number listed on our application.

Please note: An application is not a guarantee of receiving a CancerCare grant. Funds are limited and based on eligibility and availability. We are unable to process incomplete applications.



275 Seventh Avenue, Floor 22, New York, NY 10001
Phone: 1-800-813-HOPE (4673) Fax: 212-712-8495
Email: info@cancerca.org Web: www.cancerca.org

Please call for an individualized bar coded application.

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION (please print clearly)

First name: Last name: Today's date:
Address: City, State, Zip:
Phone number: Home () Work ()
Cell () Email Address
Date of birth: If patient is a minor (under 18), name of parent or guardian:
Male Female Ethnicity: White African American Latino Asian Other

MEDICAL INFORMATION

*** THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY ***

Date of diagnosis: Primary cancer: Current Stage
New diagnosis Recurrence Is patient in active treatment? Yes No
If not in active treatment, indicate frequency of follow-up: Yearly Every six months Other
Please indicate type of treatment(s) received in past twelve months (check all that apply)
Chemotherapy Radiation Surgery Hormonal Palliative care Bone marrow/stem cell transplant
*** PLEASE COMPLETE ALL FIELDS ABOVE ***

HEALTH CARE PROFESSIONAL INFORMATION (please print):

MD name: Hospital/Clinic:
Address: City, State, Zip:
Phone: () Fax: ()

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):

Phone: () Email:

Your relationship to person applying for help: Doctor Nurse Social Worker ACS Hospital Patient Navigator

Signature of MEDICAL Professional:

Incomplete applications cannot be accepted

APPLICANT'S NAME: _____

DOB: _____

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? Yes No

If yes, please indicate type of insurance (check all that apply):

Private insurance Medicaid Medicare Medicare plus Medigap Charity care VA program

Are prescription drugs covered? Yes No

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? Yes No Number of people in household: _____

FAMILY INCOME SOURCES (please check all that apply):

Social Security (retirement) Salary Pension Unemployment
 Public assistance Short-term disability SSD (Disability) SSI
 Family/friends provide support Other - specify _____

INCOME GUIDELINES ARE SET AT 250% OF FEDERAL POVERTY LIMITS AS FOLLOWS:

Household Size:	Gross Family Income	Acceptable proof of income:**
1	\$27,925	First two pages of signed copy of income tax return (you may blacken social security number) OR If you do not file a tax return: Copies of most recent pay check, unemployment check, or SSI, SSD, public assistance benefit notification
2	\$37,825	
3	\$47,725	
4	\$57,625	

TOTAL ANNUAL FAMILY INCOME **: _____

**** Application will not be processed if this information is not provided****

Please be aware that funds are limited, and based on availability as well as on meeting CancerCare's eligibility requirements. Our grants are *not* for living expenses such as rent, mortgages, utility payments or food, and we do not provide grants for medical bills or insurance co-payments. If you need this type of assistance, one of our social workers may be able to refer you to a local agency for help.

FINANCIAL ASSISTANCE NEEDS (Check all that apply):

Name of person completing this section (please print): _____ I need help with the following cancer-related expenses:

Transportation: Child care Home care Pain medications Lymphedema Supplies (for breast cancer only)

Signature: _____ Date: _____

Relationship to person applying for help: Self Spouse Family member/caregiver Health care professional

****I ATTEST BY WAY OF MY SIGNATURE THAT ANY FINANCIAL ASSISTANCE GRANTS WHICH MAY BE AWARDED WILL BE UTILIZED FOR THE EXPENSES INDICATED ABOVE****

THANK YOU.

Fax this form to (212) 712-8495 or mail to: CancerCare, 275 Seventh Avenue, 22nd Floor, New York, NY 10001.

CancerCare will review this information and contact the person requesting financial assistance.

All information is strictly confidential and is for CancerCare use only.

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