CANCERcare

**What is Financial Assistance from Cancer*Care*?**

- Cancer*Care* provides limited financial assistance to help with the costs of treatment-related transportation, child care, and home care, for all types of cancer.

- Cancer*Care*'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 | $28,725 | • **The first two pages of signed copy of income tax return.** (You may blacken out your social security number)<br>**- OR -**<br>• **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<br>**- OR -**<br>• **If you do not have income:** Provide a letter of support from friend or family member |
| 2 | $38,775 | |
| 3 | $48,825 | |
| 4 | $58,875 | |

**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 Cancer*Care* 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; and 9 a.m. – 5 p.m. Eastern Time, Tuesday – 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 Cancer*Care* mailing address and fax number listed on our application.

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

CANCERcare®

**275 Seventh Avenue, Floor 22, New York, NY 10001**
**Phone**: 1-800-813-HOPE (4673) **Fax:** 212-712-8495
**Email:** info@cancercare.org **Web:** www.cancercare.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 | $28,725 | **First two pages of signed copy of income tax return** (you may blacken social security number) |
| 2 | $38,775 | **OR** |
| 3 | $48,825 | **If you do not file a tax return: Copies of most recent pay check, unemployment check, or** |
| 4 | $58,875 | **SSI, SSD, public assistance benefit notification** |

**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 Cancer*Care'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):**

**I need help with the following cancer-related expenses:**

**Name of person completing this section (please print):** _____

❑ 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: Cancer*Care*, 275 Seventh Avenue, 22nd Floor, New York, NY 10001.**

Cancer*Care* will review this information and contact the person requesting financial assistance.

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