Dear Cancer*Care* Client,

Thank you for contacting Cancer*Care* to request financial assistance application. Please complete the patient sections on pages one and two and ask your oncology doctor, nurse or social worker to complete the medical information section the first page. *Patients or family members cannot complete the medical information section of the form*. Applicants must meet financial eligibility criteria and provide proof of income as follows:

Household Size	**Gross Family Income**	**Acceptable Proof of Income**
1	$29,175	• **The first two pages of signed copy of income tax return.** (You may blacken out your social security number) **- 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 **- OR -** • **If you do not have income:** Provide a letter of support from friend or family member
2	$39,325	
3	$49,475	
4 5 6	$59,625 $69,775 $79,925	

Please return this form and the requested documents as soon as possible. Our funds for financial assistance are limited and based on availability and **an application is not a guarantee of acceptance**. Please be thorough as all sections of the application must be completed in order for your application to be considered. A self-addressed envelope has been enclosed for your convenience, or you may fax it to the attention of the Client Access Unit at 212-712-8495.

Cancer*Care* provides free, professional support services to individuals, families, caregivers, and the bereaved to help them better cope with and manage the emotional and practical challenges arising from cancer. Our services include counseling and support groups, educational publications and workshops, and financial assistance. All of our services are provided by professional oncology social workers and are offered completely free of charge.

If you have any questions about this form or need assistance in completing it, please call 1-800-813-HOPE (4673). Our hours are Monday thru Thursday, 9 AM to 7 PM, and Fridays from 9 AM to 5 PM Eastern Time. You can also visit our website at www.cancercare.org.

All information is strictly confidential and for Cancer*Care* use only.

Sincerely,

Cancer*Care*

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

«clientcode_c» *«clientcode_c»*

«Addressee»
«address2_vc»
«address3_vc»
«city_vc», «state_c» «zip_c»

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	$29,175	**First two pages of signed copy of income tax return** (you may blacken social security number)
2	$39,325	**OR**
3	$49,475	**If you do not file a tax return: copies of most recent pay check, unemployment check, or**
4	$59,625	**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:

❑ 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.

September 2014 version 5.3