National Cancer Assistance Foundation, Inc.
140 South Beach Street, Suite 310
Daytona Beach, FL 32114
Phone (866) 413-5789
www.natcaf.org

National Cancer Assistance Foundation

Guidelines for Financial Assistance

1. Financial assistance provided by National Cancer Assistance Foundation, Inc. (NCAF) is made possible because of generous donors. It is important that these funds be available for families experiencing the greatest financial need. To apply for financial assistance, please complete the attached application. NCAF staff will contact you after your application is received.

2. Individuals must be citizens or lawful, permanent residents of the U.S. who have maintained an uninterrupted residency for 12 months without prior history of the current illness. Non-citizen residents, applying for assistance, must have and provide NCAF with a photocopy (front and back) of their I551 card (green card).

3. If a family possesses liquid assets in excess of $5,000, NCAF reserves the right to request a partial or complete spend-down prior to the approval of financial assistance.

4. All sections of the application must be completed thoroughly and accurately in order for the organization to review the request. Failure to provide complete and truthful information is a basis for denial.

5. In order to review the request for financial assistance, a hospital professional (doctor, nurse or social worker) must send a letter of support along with the application for assistance should include the following: - Individual's full name, date of birth, and diagnosis - Past treatment information - Treatment plan for the next 60 days - Other community resources being utilized

6. Assistance may be requested for up to two months or 60 calendar days. At the end of this time if additional assistance is needed, consideration will be given to those requests submitted in writing by a hospital professional. A new application is only necessary when the length of time between requests exceeds one year.

7. Financial assistance is not retroactive. Requests cannot be processed until all information is received. Financial assistance is not guaranteed and subject to availability of funds.

8. NCAF provides financial assistance for the non-medical costs of getting a patient to treatment and other expenses that may be incurred.

9. NCAF staff will contact you to determine how the organization can best help you with these expenses.

10. NCAF does not provide financial assistance with expenses outside of the U.S. and/or its

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territories.

11. NCAF is a charitable organization dependent upon the public for support. NCAF tries to maximize the limited resources available. These guidelines are a statement of NCAF's general policy, and NCAF reserves the right, in its sole discretion, to modify the same at any time without notice.

12. You will not be discriminated against or denied aid because of your race, religion, color, national origin, sex or political affiliation.

13. All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted and the availability of funds.

14. The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

The completed application should be:

Emailed to requests@natcaf.org or faxed to 941-296-7638

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Medical Information

Date of Diagnosis: _____ Diagnosis: _____

Patient is actively in treatment? ___Yes ____No

Hospital/Clinic/Medical Provider: _____

Address1: _____

Address2: _____

City, State, Zip: _____

Doctor's Name:_____ Nurse's Name: _____

Hospital Clinic Phone: _____ Fax: _____

Name of Social Worker completing this section: _____

Social Worker Phone: _____ Email: _____

The undersigned hereby acknowledges that the information submitted herein is accurate, true and complete to the best of my knowledge.

Social Workers Signature: _____ Date: _____

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Program applied to: Date of Application: _____

☐Breast Cancer Assistance Fund
☐Children's Cancer Assistance Fund
☐Children's Cancer Dream Network

Patient Information:

First Name: _____Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____Male _____Female

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____

Applicant Name: _____Relationship: _____

In a brief paragraph describe any type of assistance that would be beneficial to you or your child while going through this illness (or attach a document):

The undersigned individually and as the parent/guardian of the minor child/patient hereby acknowledges and agrees that the information submitted herein is accurate, true and complete, to the best of my knowledge. I further acknowledge and agree that by the execution of this application I am granting the National Cancer Assistance Foundation, Inc. permission to contract the medical provider(s) to confirm the foregoing information. I further acknowledge and agree that any and all sums received from the National Cancer Assistance Foundation shall be used solely for the purposes specified in this application.

Signature: _____ Relationship to Patient: _____

Printed Name: _____ Date: _____

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Consent Form

Please print clearly

I hereby give my permission for National Cancer Assistance Foundation, Inc. (NCAF) and/or its representatives to use artwork, photographs and/or letters that I provide of my family or myself in publications, slides, videotapes, motion pictures or on the internet. In addition, I hereby give my permission for NCAF and/or its representatives to photograph, audio tape record, or videotape my family or myself and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures or on the internet.

I understand these visual images or voice recordings may be used to inform families, volunteers, donors, the media and general public about NCAF programs, services or events.

I gladly give this authorization to support the efforts of National Cancer Assistance Foundation, Inc. I understand this authorization shall continue until terminated in writing.

Signing the consent form is not a requirement in order to receive assistance from National Cancer Assistance Foundation, Inc.

Signature : _____ Date : _____

Parent/guardian

Signature : _____ Date : _____
(parent/guardian signature required for minors)

Please complete one form per participant/volunteer.