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.

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

Program applied to: Date of Application: _______________

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

Patient Name (first, middle, last) ____ ☐ Male ☐ Female

Date of Birth _______ Place of Birth (State/Country) _______________________ SS# ___________________

Patient's Address ____

City/State/Zip ____

Marital status: ☐ Single ☐Married ☐Divorced ☐Cohabitants

Spouses' Name ____

Home Phone # _________________ Cell Phone # __________________ Email ___________________

Is address same as patient's? Yes No If no, address ____

City/State/Zip ____

Does Patient speak English? Yes No If no, primary language?_______________________________

How did you hear about National Cancer Assistance Foundation, Inc? _________________________

Emergency Contact Name (other than spouse listed above) ______________________________________

Relationship _________________________ Phone ____

Employment

Patient Net Annual

Employer ____ Salary _______________________

Phone # ____________________________ Is Patient on unpaid leave? Yes No

Spouse Net Annual

Employer ____ Salary _______________________

Phone # ____________________________ Is Spouse on unpaid leave? Yes No

Other Income: SSI __________________ Other ____

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Patient Name ______________________________

Banking and Investments (Please include banking information for all accounts.)
**To expedite processing your application, please include a copy of your most recent statements for all of the accounts below. 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.*

Name of Bank ______________________________

Checking Acct.# ______________________ Savings Acct.# ______________________

Checking Acct.# ______________________ Savings Acct.# ______________________

Name of Bank ______________________________

Checking Acct.# ______________________ Savings Acct.# ______________________

Checking Acct.# ______________________ Savings Acct.# ______________________

(Please include information for money markets, CDs, mutual funds, stocks, and other investments. Do not include IRA's or other retirement accounts.)

Type of Account______________________ Amount ______________________

Type of Account______________________ Amount ______________________

Fundraising
Has money been raised on behalf of the applicant? Yes No If yes, how much? ______________

How much is currently in the account? __________ Are there any restrictions on the account? Yes No

If yes, please state restrictions: ______________________________

Name of Bank ______________________________ Account # ______________

Assistance from Other Organizations
If you have applied for or received assistance from another organization, please list.
Organization ______________________ Type of Assistance ______________________

Organization ______________________ Type of Assistance ______________________

Organization ______________________ Type of Assistance ______________________

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Patient Name ________________________________

A letter from social worker, nurse or doctor explaining the patient's diagnosis, family situation, and the assistance being requested is needed in addition to the completion of this section. See guidelines for necessary information.

Name of Hospital ____________________________________ Patient Information # _________________________

Social Worker (first and last name) _________________________________ Phone # _______________________

Pager # ______________________________________ Email ____

Mailing Address ____ Dept. __________________________

City/State/Zip ____

Name of Physician (first and last name) ______________________________ Phone # ________________________

Diagnosis ____

Date of diagnosis ________________ Number of relapses _______ Date of relapse ________________________

Other treatment facility involved in patient's care ____

Social Worker (first and last name) _________________________________ Phone # ________________________

Pager # ______________________________________ Email ____

Mailing Address ____ Dept. __________________________

City/State/Zip ____

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Patient Name ________________________________

I do hereby authorize all hospitals, financial institutions, and insurance groups to release to National Cancer Assistance Foundation, Inc., or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize NCAF and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

As an inducement to National Cancer Assistance Foundation, Inc., a non-profit organization, to advance supplemental financial support in conjunction with the medical treatment of ____(patient), the undersigned to hereby affirm as follows:

1. The term “non-medical expenses” is understood to mean those reasonable and necessary expenses incurred by the family of the above-named patient or the above named patient, in conjunction with that patient receiving medical treatment. Financial assistance will be provided, with the use of said funds to be specified by NCAF.
2. The undersigned further agree(s) to return any unused funds immediately to National Cancer Assistance Foundation, Inc. so that those funds can be utilized by the organization to benefit other families.
3. The undersigned acknowledges(s) and agree(s) to maintain records that will be made available to National Cancer Assistance Foundation, Inc. upon reasonable request, detailing the expenditures made from the funds provided by the organization.

National Cancer Assistance Foundation, Inc. will pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Dated this ___ day of _________________________, in the year ________.

____ SSN: _________________________
Patient Signature

____
Please Print Name

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

Witness: ____

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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 National Cancer Assistance Foundation, Inc. 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.

Signature : ___________________________________ Date : _____________________

Parent/guardian

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

Please complete one form per participant/volunteer.