National Cancer Assistance Foundation

# Guidelines for Financial Assistance

1. Financial assistance provided by National Cancer Assistance Foundation, Inc. (Natcaf) is made possible because of generous donors. It is important that these funds be available for families and individuals experiencing the greatest financial need. To apply for financial assistance, please complete the attached application.

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 Natcaf with a photocopy (front and back) of their I-551 card (green card). If applying for Military Assistance, a copy of military ID is required.

3. 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.

4. 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. The letter 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. Must be in active treatment at time of application.

5. 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 accompanied by a hospital professional, outlining continued treatment plan and need for assistance. A new application is only necessary when the length of time between requests exceeds one year. Please submit a copy of all bills you are requesting assistance for with the application.

6. 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.

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

8. Natcaf staff may contact you to determine how the organization can best help you with these expenses.

9. Natcaf does not provide financial assistance for expenses outside of the U.S. and/or its territories. Natcaf also does not assist with medical bills, mortgages, and credit card bills.

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

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

12. All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted.

13. 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**

140 South Beach Street, Suite 310, Daytona Beach, FL 32114
Phone/Fax (866) 413-5789 www.natcaf.org

# National Cancer Assistance Foundation, Inc.
# Request for Financial Assistance

## Household Financial Information

Eligible applicants must meet specific annual income guidelines.

Annual income cannot exceed levels below:

| Household Size | Maximum Gross Family Income |
|---|---|
| 1 | $36,420 or less |
| 2 | $49,380 |
| 3 | $62,340 |
| 4 or more | $77,925 |

Number of people in patient's household: _____. Patient's annual household income: _____

Do you meet the eligibility requirements in the chart above? ____Yes. ___ No,

If no, please stop here, you are ineligible for a grant at this time.

FINANCIAL DOCUMENTATION REQUIRED

Please provide **a copy of** at least one of the following: the first two pages of last year's signed copy of your income tax return, a copy of your most recent paycheck, unemployment check, social security, SSI, SSD, or public assistance benefit notification.

Please indicate here which form of documentation you are providing: _____

**** APPLICATON WILL NOT BE PROCESSED**
**IF NONE OF THE FINANCIAL DOCUMENTS ABOVE ARE PROVIDED****

National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

**Attach Picture Here**

## Patient Information

Date of Application: _____

Program applied to:

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

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

Date of Birth _____ Place of Birth (State/Country) _____ SS#(last 4 digits)_____

Patient's Address _____

City/State/Zip _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Cohabitants ☐ Minor child

Phone # _____ Email _____

Best method to contact _____

Parents' Names (if patient is minor) _____

Spouse's Name (if applicable) _____

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?_____

**Employment**

**Patient** Net Annual Income (if patient is child- Parent information)

Employer _____ Annual Salary _____

Phone # _____ Is Patient on unpaid leave? ☐ Yes ☐ No

**Spouse** Net Annual (if patient is child- Parent information)

Employer _____ Annual Salary _____

Phone # _____ Is Spouse on unpaid leave? ☐ Yes ☐ No

**Other Income**: SSI _____ Other _____

**Household Members: (must include all members of the household)**

☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____
☐ Male ☐ Female Relationship _____ Age._____

National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

## Financial Information

**Patient Name** _____

**Parents' information if patient is a minor:**

**Financial Documentation Required**

**Banking and Investments** (Please include a copy of your most recent statements for all accounts below, if married must include all husband and wife accounts or domestic partner accounts.)

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 _____

Type of Account _____ Amount _____

**** APPLICATON WILL NOT BE PROCESSED IF NONE OF THE FINANCIAL DOCUMENTS ABOVE ARE PROVIDED****

**Fundraising**

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

Current balance 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 _____

National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

## Medical Provider Information

**Patient Name** _____

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

Name of Hospital _____ Patient ID # _____

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 _____

National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

## Assistance Request

**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 Natcaf and its representatives to provide such information to those institutions as may be reasonably required to assist myself, our family, and or 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 consider supplemental financial support in conjunction with the medical treatment of the patient named above (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 Natcaf.
2. The undersigned further agree(s) to return any unused funds immediately to National Cancer Assistance Foundation, Inc.
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.
4. Please note these donations cannot be sold, traded, bartered, returned to stores but must be used by qualified individuals in need. By signing this form, you agree to these terms.
5. **Please provide supporting documents for assistance requested such as.**

    - Invoice/Bills
    - Statements
    - Rental Agreements
    - Other details

    Requests for more than $600 may require an IRS form W-9 to be completed by the vendor.

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: (last 4 digits) _____
Patient Signature

_____
Please Print Name

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

Witness: _____

National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

## Consent to Release Information & Affirmation

Please print clearly

For consideration which I acknowledge, I irrevocably grant to The National Cancer Assistance Foundation, Inc., (Natcaf) and/or its representatives, assigns, licensees, and successors the right to use artwork, photographs and/or letters that I provide of my child, my family, or myself in publications, slides, videotapes, motion pictures or on the Internet, and in all forms and media including composite or modified representations for all purposes, including advertising, charitable solicitations, trade, or any commercial and/or charitable purpose throughout the world and in perpetuity. In addition, I hereby grant the right to The National Cancer Assistance Foundation, Inc., its subsidiaries and/or its representatives, assigns, licensees, and successors to photograph, audio tape record, or videotape my child, myself, or my family and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures or on the internet, and in all forms and media including composite or modified representations for all purposes, including advertising, charitable solicitations, trade, or any commercial and/or charitable purpose throughout the world and in perpetuity.. I waive the right to inspect or approve versions of my image used for publication or the written copy that may be used in connection with the images.

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

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

I release Natcaf and Natcaf's assigns, licensees, and successors from any claims that may arise regarding the use of my image, including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright. Natcaf is permitted, although not obligated, to include my name as a credit in connection with the image.

Natcaf is not obligated to utilize any of the rights granted in this Agreement.

***Signing the consent form is a requirement in order to receive assistance from The National Cancer Assistance Foundation, Inc.***

***Please Print Clearly***

| | | |
|---|---|---|
| Name/Child's Name: | | Date of Birth |
| Street Address | | |
| City: | State: | Zip: |
| Phone: | Cell: | Fax: |
| Email: | | |

Signer's Name _____ Date_____

Signature_____ ☐Parent ☐Guardian ☐Self

(Parent/guardian signature required for minors. If a parent/guardian is signing for minors, then they hereby attest that he/she is the parent or guardian of the minor named above and further that he/she has the legal right to consent to and do consent to the terms and conditions of this release for both the minor and the Signer.)

Please complete one form per participant/volunteer