Guidelines for Financial Assistance

1. Financial assistance provided by National Cancer Assistance Foundation, Inc. (Natcaf) is made possible because of generous donors. Funds are provided for emergency assistance to underserved applicants and families experiencing the greatest financial need. To apply for financial assistance, please complete the attached application.

2. Individuals must be citizens, or a lawful, permanent residents of the United States, 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 copy (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 addressed to Natcaf on their letterhead, 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. 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. Provided funding is available. First time applicants are prioritized over requests for additional 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 applicant 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 please provide an email address for all communications. All communications will be by email only.

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 payments.

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 applicants deemed to have the greatest need, at the time of submission, based on funding available.

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

(Natcaf does not operate or accept applications from the following states IA, MI, OR.)

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

Applicant Name: ______________________

Eligible applicants must meet specific annual income guidelines.

Annual income cannot exceed levels below:

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Maximum Gross Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$36,420 or less</td>
</tr>
<tr>
<td>2</td>
<td>$49,380</td>
</tr>
<tr>
<td>3</td>
<td>$62,340</td>
</tr>
<tr>
<td>4 or more</td>
<td>$77,925</td>
</tr>
</tbody>
</table>

Number of dependents* in applicant’s household: _____ (must match number of dependents claimed on tax return)

Applicant’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.

Are you a U.S. Citizen? ☐ Yes ☐ No, If no, Non-citizen residents, must provide Natcaf with a copy (front and back) of their I-551 card (green card).

FINANCIAL DOCUMENTATION REQUIRED

The following must be provided:

1. Signed copy of the first two pages of last year’s income tax return for all applicants/parents/guardians income tax return as filed.

2. Copy of most recent paycheck, unemployment check, social security, SSI, SSD, or public assistance benefit notification for all applicants/parents/guardians.

**APPLICATON WILL NOT BE PROCESSED IF THE FINANCIAL DOCUMENTS ABOVE ARE NOT PROVIDED**
Date of Application: ________________

**Must choose at least one to apply for:**

- [ ] Breast Cancer Assistance Fund
- [ ] Children’s Cancer Assistance Fund
- [ ] Children’s Cancer Dream Network
- [ ] Military Cancer Assistance Fund

Applicant Name (first, middle, last) ________________________________________  [ ] Male  [ ] Female
Date of Birth ____________ Place of Birth (State/Country) ____________________ SS# (last 4 digits) __________
Applicant’s Address ________________________________________________________
City/State/Zip _____________________________________________________________
Marital status:  [ ] Single  [ ] Married  [ ] Divorced  [ ] Cohabitants  [ ] Minor child
Phone # ___________________ Email ______________________________
Best method to contact _______________________________________________________
Parents’ Names (if applicant is minor) __________________________________________
Spouse’s Name (if applicable) ________________________________________________
Is address same as applicant’s?  [ ] Yes  [ ] No  If no, address __________________________________________
City/State/Zip ______________________________________________________________
Does Applicant speak English?  [ ] Yes  [ ] No  If no, primary language? ______________________________
How did you hear about National Cancer Assistance Foundation, Inc? ______________________________

**Employment**

**Applicant**
Gross Annual Income (if applicant is child- Parent information)
Employer ______________________________________________________ Annual Salary ________________________
Phone # _______________________________ Is Applicant on unpaid leave?  [ ] Yes  [ ] No

**Spouse**
Net Annual (if applicant 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

Applicant Name: __________________________

Parents’ information if applicant is a minor: __________________________

Housing- □ Rent □ Own □ Other __________________________ Monthly Payment: $ __________________________

Financial Documentation Required

Banking/Investments/Cash/payment App* (Please list below and include a copy of your most recent statements for all accounts, if married must include all spouse, or domestic partner accounts. *PayPal, Apple pay, Venmo, or others)

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 __________________________

(If you do not have any of the above accounts, you must send payment records for current household expenses, rent/mortgage, utilities, transportation, etc.)

** APPLICATON WILL NOT BE PROCESSED IF ABOVE ACCOUNTS OR PAYMENT DOCUMENTS ARE NOT 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 __________________________

**Failure to provide complete and truthful information is a basis for denial**
National Cancer Assistance Foundation, Inc.
Request for Financial Assistance

Medical Provider Information

Applicant Name __________________________

A letter from social worker, nurse or doctor on their letterhead, explaining the applicant’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 __________________________ Applicant 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 applicant’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

Applicant 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 applicant named above (applicant), 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 applicant or the above-named applicant, in conjunction with that applicant 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. All applications will be reviewed on a case-by-case basis and final determination will be made based upon applicants deemed to have the greatest need, at the time of submission, based on funding available.

6. 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. I understand that any false or omitted information will be cause for denial of assistance.

Dated this ______ day of ______________________, in the year ____________.

_________________________________  SSN: (last 4 digits) __________________

Applicant Signature (typed signature not acceptable)

Please Print Name

Signature: ____________________________ Date: ____________________

(parent/guardian signature required for minors typed signature not acceptable)
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

<table>
<thead>
<tr>
<th>Name/Child’s Name:</th>
<th>Date of Birth</th>
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<table>
<thead>
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<table>
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<th>Zip:</th>
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<table>
<thead>
<tr>
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<th>Cell:</th>
<th>Fax:</th>
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<th>Email:</th>
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Signer’s Name _________________________ Date___________________

Signature_______________________________________________ □Parent  □Guardian  □Self

(Signature required typed signature not acceptable)

(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.)