Universal Financial Assistance Application Instructions - Breast Cancer Patients (2/15/24)

1. Hospital/Medical Providers signature is required on page 1 of the application.
2. Proof of Income Documentation requirement.
    a. List of acceptable proof of income documentation
        i. **Copy of most recent Federal Income Tax filing (page 1 & include page 2 if applicable of your 1040 form)** *IMPORTANT: If you do not file Federal Income Tax forms, please note this on page 1 of the application
        ii. **If you are currently receiving Unemployment Insurance benefits, Disability benefits, or Workman's Compensation benefits, please submit a copy of your benefit letter.**
        iii. **If you do not file an income tax return, please submit the following documentation, if applicable:**
            1. Copy of Medicaid / Social Services benefits statement
            2. Copy of Social Security benefits statement
            3. Copy of retirement fund and / or annuity statement

Both a medical provider's signature and proof of income are required for your application to be processed. Failure to provide these will result in a longer application review period.

Please provide invoices or bills to be paid. (We prefer originals, but can accept good, legible photocopies.) **NOTE: We cannot accept photos of this application, income documentation, and/or bills for payment.**

NOTE: We cannot reimburse the patient for any bills already paid. All expenses are paid directly to the provider/vendor.

Questions?

Contact us at (315) 634-5004 or OfficeCancerConnects@gmail.com

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Universal Financial Assistance Application – Breast Cancer Patients (2/15/2024)

You must be a resident of and/or receiving cancer treatment in one or more of the following counties to be eligible for this financial assistance program:

CAYUGA ● CORTLAND ● MADISON ● ONEIDA ● ONONDAGA ● OSWEGO ● JEFFERSON ● ST. LAWRENCE ● ADJACENT AREAS

Please provide invoices or bills to be paid. (We prefer originals, but can accept good, legible photocopies.)
NOTE: We cannot accept photos of this application, income documentation, and/or or bills for payment.

All expenses are paid directly to the provider/vendor. We cannot reimburse the patient for any bills already paid.

Only 1 application may be submitted. We MAY provide you with a renewal application after six (6) months if you are still in treatment and need financial assistance.
You may reapply for NEW financial grant assistance only if you have a recurrence/special circumstances.

Patient Name: _____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip: _____

Phone number: _____ E-mail Address: _____

What is your cancer diagnosis? _____ When were you diagnosed? _____

How did you hear about our financial assistance program? _____

Hospital/Medical Provider attestation that applicant is a breast cancer patient:
Name of Hospital/Medical Provider (must print below):

_____
Office Address City State Zip

_____
Phone # for office to confirm information | Printed name of Doctor/ Medical Provider | Signature of Doctor/ Medical Provider

☐ Yes, I have medical insurance (please see below) ☐ No, I do not have medical insurance

Insurance Provider(s): _____ Group/Policy Number(s): _____

Do you have an annual deductible? _____ Deductible Amount: $_____ Out-of-Pocket (OOP) Limit: $ _____

Annual household income: $ _____ # of people in household? _____
*(**ATTACH ALL Proof of Income documentation** – see page 2 for list of acceptable documents.)*

Are you currently working? _____ ☐ F/T ☐ P/T Employer: _____

Are you self-employed? _____ Have you lost time from work due to your cancer diagnosis? _____

Amount of Financial Request: $_____ *(Note: We cannot reimburse for bills already paid)*

Reason for Request (please be specific and tell us what you need to use financial assistance for):

_____

Any special circumstances we should know about? (please attach an additional sheet if necessary):

_____

Have you received assistance from the Saint Agatha Foundation in the past? ☐ YES ☐ NO

If YES… when? _____ How much ($$)? _____

Please note that our financial assistance priorities are as follows in order of importance:
Medical bills not paid by insurance, co-pays, prescription drugs (related to cancer diagnosis), health insurance premiums & supplemental insurance premiums, medical garments & apparatus, gas & transportation for medical appointments, groceries & nutrition, wigs, non-medical necessary living expenses up to **three (3)** months while in active treatment.

We cannot pay for:
Tax bills of any kind, vendor bills where total owed is less than $10, auto loans where auto is already in repossession or payments are more than 1 month behind, premium cable bills items (such as pay-per view or movie rentals), auto insurance, household repairs not related to health/safety, legal fees, DMV fees, late fees, water bills, medical bills from a collection agency, fertility treatment bills, security deposits, or family members' medical bills.

List of Acceptable Proof of Income Documentation

- **Copy of most recent Federal Income Tax* filing (page 1 & include page 2, if applicable)**
  **IMPORTANT: If you do not file Federal Income Tax forms, please note on page 1 of this application.*
- **If you are currently receiving Unemployment Insurance benefits, Disability benefits, or Workman's Compensation benefits, please submit a copy of your benefit letter.**
- **If you do not file an income tax return, please submit the following documentation, if applicable**
  - Copy of Medicaid / Social Services benefits statement
  - Copy of Social Security benefits statement
  - Copy of retirement fund and/or annuity statement

I understand that CancerConnects and Saint Agatha Foundation will keep in extreme confidence any information provided by myself and /or family members at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or family member. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself.

In connection with this application, I hereby authorize my health care providers to disclose to Saint Agatha Foundation and CancerConnects (collectively, the "Funders") the specific information requested on this form. This is for the purpose of determining my eligibility for the assistance I am seeking. I agree that any of my healthcare providers may rely on a copy of this authorization once signed below. I understand that once my personal health information is received by any of the Funders, its confidentiality may no longer be protected under Federal Law. However, the Funders will not re-disclose this information to any other party.

_____ _____
Applicant Signature Date

Please return your completed application with proof of income documentation to:
Mail: CancerConnects, P.O. Box 2010, East Syracuse, NY 13057
Email with legible scan of documents: ***OfficeCancerConnects@gmail.com***
NOTE: We CANNOT accept photographs of applications or financial documentation

If you need assistance completing this application, please contact our office at: (315) 634-5004

This grant is provided through generous funding from the Saint Agatha Foundation.