CancerConnects, Inc. & Saint Agatha Foundation

Financial Assistance Application – Breast Cancer Patients

Eligibility

To qualify for the financial assistance program, you must be a resident of and/or receiving cancer treatment in one of the following New York counties: Cayuga, Cortland, Madison, Oneida, Onondaga, Oswego, Jefferson, St. Lawrence and adjacent areas.

IMPORTANT: Proof of income must be submitted with application. Do not submit bills with application.

Have you received help from the Saint Agatha Foundation before? Yes_____ No _____
If yes, when? _____ How much was awarded ? $_____
How did you hear about our financial assistance program? _____

Patient Information

Full Name: _____
Date of Birth: _____
Address: _____
City: _____County: _____State: _____ ZIP: _____
Phone: _____ Please check if ok to leave message on voicemail_____
Email: _____

Cancer Diagnosis

Diagnosis: _____
Date of Diagnosis: _____

Insurance & Income

Do you have medical insurance? Yes _____ No_____
Insurance Provider: _____ Policy Number: _____
Annual Deductible: $_____
Out-of-Pocket Max: $_____ is deductible included in Out- of -Pocket_____
Annual Household Income: $_____ # of People in Household: _____

Employment

Are you currently working? Full-Time _____Part-Time_____ No_____
Employer Name (if any): _____
Are you self-employed? Yes_____No_____
Have you lost time from work due to your diagnosis? Yes_____ if yes, for how long _____No_____

Financial Request

- Amount Requested: $_____
- Reason for request (please be specific about how funds will help-Medical bill, rent, transportation, etc.) Also, any special circumstances we should know (Attach additional page if needed)

_____
_____
_____
_____

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Medical Provider Attestation

I hereby certify that I am currently providing medical treatment to the patient named below for the diagnosis of breast cancer.

Patient Name: _____

Diagnosis: _____

Date of Diagnosis: _____

Current Treatment Status:

Active Treatment_____

Maintenance Therapy_____

Surveillance and Follow-up_____

Metastatic? _____

Medical Provider Name: _____

Signature_____

Office Phone: _____

Email: _____

Office Address: _____

_____

_____

Financial Assistance Guidelines and Patient Consent Form

We're Here to Help

We know cancer care can often come with unforeseen financial challenges. Our goal is to help ease the burden by supporting you with certain expenses.

We do prioritize medical related bills such as co-pays, prescription drugs related to diagnosis, health insurance premiums, supplemental insurance premiums, medical garments and apparatus. We also cover the following: Gas and transportation for medical appointments, groceries and nutrition, wigs, non- medical living expenses up to 3 mos. while in active treatment.

Please read below to understand our financial assistance policies further.

What You Need to Know

- We can help with bills starting from the date of your cancer diagnosis. We cannot cover anything from before that date.
- Your bill must be related to your current cancer treatment.
- We cannot reimburse for any bills that have already been paid.
- You must send us the full bill—not just a summary or photo. We need to see the dates of services, services provided and total amount.
- We do not accept photos of bills. Please scan or mail us a copy.
- Bills are due to our office by the 10th or 25th of the month.
- It may take up to 15 business days to process payments.
- Your file will be closed if there is more than 6 months of inactivity.

We Cannot Help With

- Taxes or water bills
- Car insurance or auto loans
- Credit cards, Care Credit, Collection Agencies or late fees
- DMV fees or impounding fees
- Legal fees
- Fertility treatments
- TV, Premium Cable, phone extras (accessories), family members' cell phone lines
- Medical bills for family members
- Medical bills unrelated to diagnosis
- Dental care not caused by cancer treatment
- Bills $10 or less
- Any bills from before your diagnosis date
- OTC items, if returned without a refund, will not be credited back into your account
- House-hold repairs that are not related to diagnosis, health or safety

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 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
• If you are currently receiving Unemployment Insurance benefits, Disability benefits, or Workman's Compensation benefits, please submit a copy of your benefit letter.

CancerConnects, Inc. & Saint Agatha Foundation

I understand that CancerConnects, Inc. 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**_____

Consent to Share Information

We cannot share information without your consent. By signing this consent form, we would be able to give information to any family member or friend that you have listed below.

I, _____, hereby give consent to CancerConnects, Inc. to talk to the following person or persons:

Family/ Friend Information:

1. Full Name _____Phone Number_____

   Relationship to patient: _____ Email Address_____

2. Full Name _____Phone Number_____

   Relationship to patient: _____ Email Address_____

3. OR Decline to give information _____

This authorization will remain in effect unless notified, in writing, that the authorization is no longer effective.

Name_____Date of Birth_____

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 pdf scan of documents: OfficeCancerConnects@gmail.com
PLEASE NOTE: We CANNOT accept photographs of applications or financial documentation

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If you have any questions, need assistance completing this application, or help understanding your bill, please contact our office at: (315) 634-5004 or email officecancerconnects@gmail.com