Atlanta Cancer Care Foundation, Inc.

Application for Patient Financial Assistance Grant

ALL SECTIONS MUST BE COMPLETED IN FULL

Fax completed application to (678) 348-7523
or email to courage@atlantacancercarefoundation.org
Updated 1/2015

PATIENT INFORMATION

Name: _____ **Date of Application:** ___/___/_____

Street Address: _____

City/State/Zip: _____ County:_____

Phone Number: (____) _____ Alternate Phone Number (optional): (____) _____

Email address (optional): _____

If patient is not an English speaker, or is currently unable to speak on the phone due to illness or hospitalization, provide contact information for a friend or family member authorized by the patient to speak with us about this application:

Name: _____ Phone: (____) _____ Relationship: _____

Patient Gender: □ Male □ Female **Date of Birth:** ___/___/_____ **Number of people in household:** _____

Marital status: □ Single □ Married □ Separated /Divorced □ Widowed **Minor children in the home?** □ Yes □ No

Employment status: □ Employed full-time □ Employed part-time □ Unemployed □ Retired □ Disabled

Source(s) of income: □ Wages/salary □ Unemployment benefits □ Pension □ TANF □ Social Security Retirement

□ Long Term Disability □ Short Term Disability □ SSI □ SSDI □ Child Support □ In-Kind (room & board)

□ Alimony □ Family/friends provide support □ Other: _____

Patient Insurance Status: □ Private Insurance □ Medicare □ Medicaid □ Uninsured

Is the patient's current need for financial assistance a direct or indirect result of cancer treatment? □ Yes □ No

Which type of expense is the patient seeking assistance with?

□ Utilities (electric, gas, propane, water, phone) □ Rent/mortgage □ Auto loan or insurance □ Gas cost

□ Medical insurance premium/co-pays □ Prescription costs □ Durable medical equipment costs □ Groceries

□ Other – specify: _____

Attach copy of the bill(s) the patient would like to have considered for assistance, if applicable. Copy must show name on the account, account number and service address (for utility bills). If bill is not available when application is submitted, it may be submitted separately by either the patient or the referring professional; however, **we will not issue a check toward any bill until a copy of the bill is received**.

- Utility or mortgage bills can be accepted in the name of spouse, partner or caretaker living at the same address.
- For rent assistance, submit either a copy of lease agreement or letter from landlord verifying that patient is a tenant and including landlord's name, address and phone.
- We do not pay medical bills owed to the referring practice, facility or hospital.
- We do not issue checks payable to the patient. Checks are made payable to the company owed.

MEDICAL VERIFICATION – TO BE COMPLETED BY REFERRING PROFESSIONAL

Type of cancer: _____ Date of diagnosis (Month/Year): ___/_____

Please provide information about treatment below:

Chemotherapy	Radiation	Hormone treatment	Surgery
Start date;___/____/_____	Start date___/___/_____	Start date___/___/_____	Date___/___/_____
End date:____/___/_____	End date___/___/_____	End date___/___/_____	

If patient is not receiving active treatment, is he/she receiving follow up care? □ Yes □ No

Oncologist: _____ Practice/Facility/Hospital: _____

Practices or treatment facilities with multiple locations -- which location? _____

REFERRING PROFESSIONAL

Name & Title (PRINT CLEARLY): _____

Practice/Facility/Organization: _____

Contact information (phone and/or email): _____

I have reviewed this application and I verify the diagnosis and treatment information.

Referring Professional Signature: _____ **Date:** ___/___/_____

If patient is not present to sign the application, you MUST read the statements below to the patient and obtain verbal consent, then initial here to indicate that you have done so: _____ (Initials of referring professional)

APPLICANT (PATIENT)

All of the information I have provided for this application is true and correct. I understand that any financial assistance provided by the Atlanta Cancer Care Foundation (ACCF) is limited to ACCF's funding guidelines, and that assistance is available one time only. I assert that to the best of my knowledge, I have not previously received assistance from ACCF.

I authorize my healthcare provider(s) to release information to ACCF related to this application. I understand that information provided to ACCF will remain confidential, except that ACCF may disclose information to my creditors and others as may be necessary to provide financial assistance. I understand that I remain fully responsible for timely payments of my debts, and indemnify and hold harmless ACCF for any expenses, losses or liabilities arising from or related to my debts.

Signature of Applicant: _____ Date: ___/___/_____

FOR ACCF USE ONLY:

Signature of ACCF Board Member: _____ Date: ___/___/_____