Application for Patient Financial Assistance

ALL SECTIONS MUST BE COMPLETED IN FULL

Fax completed application to (678) 348-7523
or email to courage@atlantacancercarefoundation.org
Updated 7/2023

PATIENT INFORMATION **DATE OF APPLICATION:** ________________

Name: ____ **Date of Birth:** __________________

Street Address: ____

City/State/Zip: ____ **County:**_____________________

Phone Number: (____) ______________________ **Alt. Phone Number (optional):** (____) _____________________

Email address: ____

Emergency Contact:
If patient is currently unable to speak on the phone <u>due to illness or hospitalization</u>, *or is not an English speaker, 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 □ Nonbinary □ Transgender □ Other

Marital status: □ Single □ Married □ Partnered □ Separated /Divorced □ Widowed

Number of people in household: _________ **Minor children in the home?** □ Yes □ No

Race: □ White □ Black/African American □ Asian □ American Indian/Alaskan Native
□ Native Hawaiian/Other Pacific Islander □ Middle Eastern/North African □ Multi-Racial □ Other

Ethnicity: □ Hispanic, Latino, Spanish descent □ Not of Hispanic, Latino, Spanish descent

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

Estimated total household income (from all sources): $________________ per □ week □ month □ year

Source(s) of income: □ Wages/salary □ Unemployment benefits □ Pension □ Social Security Retirement
□ Long Term/Short Term Disability □ SSI or SSDI □ Public Benefits □ Alimony/Child Support □ Family/friends
□ Other: ____

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

Does the patient qualify for financial assistance from their provider's office or treatment facility? □ Yes □ No

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

How would the requested financial assistance impact the patient and their financial situation? *(please check all that apply)*
□ Meet basic needs □ Reduce levels of financial stress □ Remove a barrier to treatment
□ Other: ____

FOR ACCF OFFICE USE ONLY:

Type of Assistance Provided: □ Food Assistance □ Housing □ Living Expenses □ Medical Expense
□ Transportation □ Utilities □ Other: ____

Patient Name: ______________________________

Patient Phone: ______________________________

Application for Patient Financial Assistance

MEDICAL VERIFICATION – TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Type of cancer: ____ Date of diagnosis (Month/Year): ____________

Date of last cancer treatment (treatment is defined as: chemotherapy, radiation therapy, hormonal or biological treatment, surgery or other methods) (Month/Year): ______________

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

Physician Name: ________________________ Practice/Facility/Hospital: ___________________________________

Practices or treatment facilities with multiple locations – Please provide physical address:

____

REFERRING PROFESSIONAL PAYMENT REQUEST

Please pick the category that best describes how this request benefits the individual? Check all that apply for the bills/requests submitted with this application.

	Rent/mortgage payments
	Utility bills for gas, electric, water, propane, etc.
	Prescription co-pays
	Grocery costs (gift card request)
	Transportation costs (gift card request)
	Other: ____

A bill MUST be provided with all requests (outside of gift card requests).

Bill Name, Address, Phone (*all required)	Account # (*required)	Amount Requested (*required)
	Total request amount (standard grant is $250):	

Attach bills to support each request *except if requesting gift cards*. We cannot provide assistance without a bill attached.

I reviewed this application and I agree with the funding need. By submitting an application on behalf of a patient, I attest that I provided the patient with a broad overview of ACCF's Patient Financial Assistance Program and its policies, and that the patient or their caregiver/emergency contact selected the particular requests I am submitting as their greatest need at this time.

Referring Professional (print name & date):___________________ Referring Professional (signature):____________________

Referring Professional Title & Organization:____

Phone:________________________Email:____

Referring Professional: 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)

Patient Name: ____

Patient Phone: ____

Application for Patient Financial Assistance

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 at the time of application, and may be limited to one time only.

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:** ___/___/________

Atlanta Cancer Care Foundation, Inc.

Application for Patient Financial Assistance

Updated 12/2021

Thank you for your interest in the Atlanta Cancer Care Foundation (ACCF) Patient Financial Assistance program. ACCF's mission is to alleviate the financial burden felt by patients and families who are struggling financially because of a cancer diagnosis. To do this, the Foundation makes grants to assist eligible patients with their greatest financial needs.

In order to be eligible for a grant through the Patient Financial Assistance programs, an applicant must:

- Be at least 18 years old
- Live in, or receive treatment in, ACCF's 17-county service area (**Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale & Walton counties**)
- Have a cancer diagnosis, certified by a healthcare provider
- Be in active treatment for cancer, or have completed active treatment within the past 12 months, or have declined active treatment and been admitted to hospice care.

Grants are not made directly to the patient; checks are made payable to the company owed. Copies of the bill(s) the patient would like to have considered for assistance MUST be attached. Copies must show the name on the account, account number and service address (for utility bills).

- 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.
- Requests for assistance with food costs or fuel costs do not require a bill to be submitted.

Please note that applications must be submitted by a referring professional (i.e. the patient's doctor, nurse, social worker, or other health care professional). **The application must be filled out completely, including patient information, medical verification, and Referring Professional and Patient signatures.**