NEW YORK CANCER FOUNDATION

PATIENT ASSISTANCE POLICY GUIDELINES & APPLICATION

The NY Cancer Foundation is a 501(c)(3) nonprofit organization which offers financial assistance to patients in the Greater Metro Area who are actively undergoing cancer treatment. The Foundation strives to relieve qualified patients of financial stress. The following are examples of day-to-day living expenses with which we may assist:

- **Rent or Mortgage Payments**
- **Utility Payments (water, sewer, electric)**
- **Telephone payments (landline or mobile)**

Qualifications

In order to qualify, the patient and/or spouse must:

- **Be 18 years or older**
- **Be a legal resident of the United States**
- **Have an annual income at or below 300% of the national poverty level (see chart below)**
- **Be actively receiving treatment from a community oncology practice**

An applicant may qualify for consideration based on a combination of the following financial criteria:

- **Have no more than $5,000 total in liquid assets (liquid assets are defined as cash, checking or savings accounts, stocks, etc.) for patients and spouse combined**
- **Spouse or patient owns no secondary investment property**
- **Income falls within the following guidelines**

Funds Availability

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

For families/ households with more than 8 persons, add $4,320 for each additional person.

Persons in family household	Poverty Guideline (300%)
1	$36,180
2	$48,720
3	$61,260
4	$73,800
5	$86,340
6	$98,880
7	$123,960
8	$123,960

The maximum amount of a grant per patient is $2500 annually for debts incurred while actively receiving treatment. The Foundation reserves the right to suspend grant allocations based upon resources available. NY Cancer Foundation does not pay patient medical bills, co-payments, or credit card bills of any kind and does not provide cash grants directly to patients. Upon approval, payment will be made directly to the creditor. As funds are limited, NY Cancer Foundation encourages all patients to create a plan for long term support and assistance, and to contact additional community resources.

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Section 1: PATIENT INFORMATION

Last Name: ________________________________ First Name: ____________________________

Address: __________________________________ City/Zip: ______________________________

Phone Home: ___________________ Work: _________________ Cell: ______________________

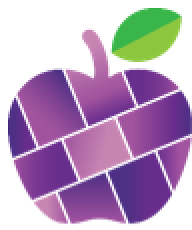
Email: __________________________ ☐ Male ☐ Female Birth Date: ____________________

Are you a legal resident of the United States? ____Have you received help from NY Cancer Foundation before? ___

Are you a patient of **NY Cancer & Blood Specialists**? If not, please provide documentation from your oncologist stating that you are currently undergoing treatment for cancer :__________

Section 2: FINANCIAL INFORMATION

Monthly Family Expenses	Amount	Family Assets	Amount
Rent/Mortgage	$	Checking	$
Phone	$	Savings and/or Money Market	$
Home: Electric	$	Investments	$
Home: Gas	$	Other (specify)	$
Home: Water	$	Family Assets Total	$
Cable	$		
Child Care	$		
Transportation	$		
Health Insurance	$		
Medical Bills	$		
Food	$		
Other (specify)	$		
Monthly Expense Total	$		



NEW YORK CANCER FOUNDATION

The following items MUST be attached in order for the application to be processed:

A. Please check all that apply and attach copies of Income Documentation

☐ Pension ☐ Public Assistance ☐ Short Term Disability/Sick Leave Pay ☐ Social Security(retired)
☐ Child Support ☐ Alimony ☐ SSI/SSDI ☐ Unemployment ☐ Salary

B. Verification of household assets **(attach the following to application)**

- W-2
- 3 months most recent bank statements for **ALL** bank accounts
- SSI Letters for applicants, spouse and other household members

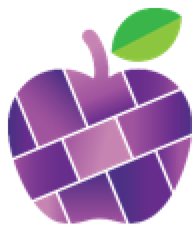
C. If requesting rent assistance, please attach a copy of your rental agreement

D. If requesting mortgage, please attach copy of your latest mortgage statement

ITEM	AMOUNT	COMMENTS
Auto		
Rent		
Mortgage		
Utility		
Other		

E. Number of persons living in household including non-family & children: __________

ONLY FULLY COMPLETED APPLICATIONS (WITH DOCUMENTATION) WILL BE PROCESSED



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1. To what other organizations have you applied for financial assistance? ________________________
2. Are you now or will you be receiving assistance from another organization(s)? ☐ YES ☐ NO
3. If YES, provide details and amount.

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4. What insurance do you have? ____________________________

ADDITIONAL COMMENTS:

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☐ ***I would be willing to share my story for patient testimonials***

My Story:

GENERAL RELEASE

I understand that my participation in the New York Cancer Foundation is voluntary and these benefits are a humanitarian endeavor to provide financial support to patients who are battling cancer who are experiencing financial difficulties.

I release, discharge and agree to hold harmless New York Cancer Foundation, its Board, sponsors, employees and volunteers from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by the New York Cancer Foundation.

I release authority to gather medical information and records requested as to my condition.

I recognize that in the event checks are not received by the creditor or sent to the incorrect location based on the information provided, the New York Cancer Foundation is not responsible for stop payment fees incurred and it will be deducted from the allotted grant monies.

I attest that the information provided is accurate and truthful. I understand that I may be required to reimburse the New York Cancer Foundation for all or some of the monies granted, in the event that it is not.

I agree to all of the above. Signature: ________________________________

Print Name: ______________________________

Home Address: ____

Last 4 digits of Social Security Number: _______________________________

Phone Number: ____

Email: ____

Date: ____

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