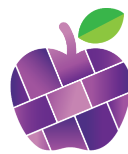


NEW YORK CANCER FOUNDATION

Advocates For Hope

2020 TRAVEL 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 (within the counties of New York City, as well as Nassau & Suffolk) who are actively undergoing cancer treatment. The Foundation strives to relieve qualified patients in financial need by providing transportation to and from cancer treatments within *25 mile* range of treatment center. Grants up to $500 annually **(unless specifically approved by the Board of Directors and not to exceed $3,000)** may be awarded to those who meet the financial qualifications.

Qualifications

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

- **Be 18 years of age or older**
- **Be a legal resident of the United States**
- **Have an annual income at or below 300% of the national poverty level (see 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:**

2020 Funds Availability

2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

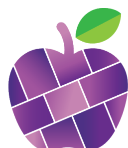
For families/ households with more than 8 persons, add $4,420 for each additional person.

Persons in family household	Poverty Guideline (300%)
1	$38,280
2	$51,720
3	$65,160
4	$78,600
5	$92,040
6	$105,480
7	$118,920
8	$132,360

The maximum amount of a grant per patient is $500 annually for transportation 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 direct patient cash grants. Upon approval, payment will be made directly to the creditor. No physician or staff member is eligible to receive any financial distributions from NY Cancer Foundation. As funds are limited, NY Cancer Foundation encourages all patients to create a plan for long-term transportation if necessary.

How to Apply:

The Foundation application is accepted by email info@nycancerfoundation.org or mail to New York Cancer Foundation,1201 Route 112 Suite 350, Port Jefferson Station, NY 11776. Please contact the Foundation at (833)-588-6923 with any questions. Please allow 21 days for application review and payment processing.



NEW YORK CANCER FOUNDATION
Advocates For Hope

Section 1: PATIENT INFORMATION

Last Name: ______________________________ First Name: __________________________________

Address: ________________________________ City/Zip: ____________________________________

Phone Home: ____________________ Work: _____________________ Cell: ______________________

Email: _____________________________ Male Female Birth Date: ______________________

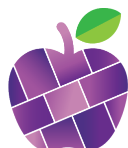
Are you a legal resident of the United States? _____ Have you received help from **NY Cancer Foundation** before? _____

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: ____________

Number of persons living in your household including non-family and children: ______________________

Section 2: FINANCIAL INFORMATION

Monthly Family Expenses	AMOUNT	Family Assets	AMOUNT
Rent	$	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	$		



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Section 2: *Continued*

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

Please check all that apply and attach copies of Income Documentation

☐ Pension ☐ Public Assistance ☐ Short Term Disability/Sick Leave Pay ☐ Social Security

☐ Child Support ☐ Alimony ☐ SSI/SSDI ☐ Unemployment ☐ Salary ☐ Medicaid

☐ Medicare

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: ______________________

4. What insurance do you have? ______________________

PLEASE ATTACH THE FOLLOWING

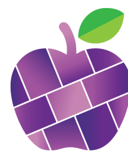
A. Copies of your current bills for items you would like to receive financial assistance. Please continue to pay any bills until you receive notification of approval.

B. Verification of household assets- W2, 3 months most recent bank statements for all accounts, and SSI letters for applicant, spouse and other household members living with you (if applicable). If no bank accounts or income, please include a notarized letter stating such.

C. Please attach a copy of your rental agreement or mortgage statement.

ITEM	AMOUNT	COMMENTS`
Auto		
Rent		
Mortgage		
Utility		
Other		

ADDITIONAL COMMENTS:______________________



SECTION 3: GENERAL RELEASE

I/We understand that our 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/We release, discharge and agree to hold harmless the 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 travel assistance program or benefits provided by the New York Cancer Foundation. I/We release authority to gather medical information and records requested as to my condition.

I agree to all of the above.

Signature:____

Print First & Last Name: ____

Home Address: ____

Last 4 digits of Social Security Number: ____

Phone Number: ____

Email: ____

Date: ___________________________________

ONLY FULLY COMPLETED APPLICATIONS WILL BE PROCESSED