



2021 TRAVEL ASSISTANCE POLICY GUIDELINES & APPLICATION

The NY Cancer Foundation is a 501(c)(3) nonprofit organization which offers financial assistance to patients who are actively undergoing cancer treatment in the Greater Metro Area (within the counties of New York City, as well as Nassau & Suffolk). The Foundation strives to relieve qualified patients in financial need by providing transportation to and from cancer treatments within a 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 \$10,000 total in liquid assets (liquid assets are defined as cash, checking or savings accounts, stocks, etc.) for patients and household combined.
- Spouse or patient owns no secondary investment property.
- Income falls within the following guidelines:

2021 Funds Availability

2021 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family household	Poverty Guideline (300%)
<i>For families/ households with more than 8 persons, add \$4,540 for each additional person.</i>	
1	\$38,640
2	\$52,260
3	\$65,880
4	\$79,500
5	\$93,120
6	\$106,740
7	\$120,360
8	\$133,980

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.



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	\$		



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 Other

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:

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 (if applicable)
- If no bank account or income, please include a notarized letter stating such

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****