

Patient Assistance Program Policies and Guidelines

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Through funds from the Cancer Challenge, the Ozark Affiliate of Susan G. Komen for the Cure, the Winthrop Rockefeller Cancer Institute Auxiliary, other private foundations and agency fundraisers, Hope Cancer Resources is able to provide gifts to patients for emergency needs, including prescriptions. All requests must come to Hope Cancer Resources via our universal application. Because of the demand for assistance, oral requests cannot be accepted. Incomplete applications also cannot be considered. Our funds are limited; therefore, the more information that we have the easier it is for us to make good and timely decisions regarding assistance.

It is our goal to provide an answer regarding assistance as soon as possible. Please allow one business day for medication requests and up to 5-7 business days for other types of assistance.

The following requests for assistance will be considered:

- Medication (up to \$500)
- Counseling
- Dental Needs
 - Must be directly related to cancer treatment
- Other Emergency Needs (up to \$800*)
 - Housing Needs such as
 - Rent/Mortgage
 - Home owners insurance
 - Transportation needs such as
 - Car Payments
 - Gasoline (gas cards provided)
 - Travel needs for out of town treatment (hotel, airfare)

****While gifts can be up to \$800, this amount is not guaranteed for every patient. Generally, emergency assistance gifts average between \$300 to \$500.***

At this time Hope Cancer Resources is unable to assist with food, clothing expenses and medical bills. We will make every effort to make referrals to other agencies that might be able to assist with those needs.

Requests for assistance are considered on a case-by-case basis. Applications will be evaluated on:

- Lack of prescription drug coverage through insurance (for medication assistance)
- Medication not covered by any company-sponsored assistance program
- Patient is unable to pay for expense out of pocket based on patients assets and income level
- Urgency of need
- Availability of Hope Cancer Resources funding

Priority will be given to patients whose prolonged treatment has prevented them from working, patients with no medical insurance and those with extremely limited financial means.



Application for Assistance

Date of Application: _____ **Application Completed By:** _____

Medication Assistance Emergency Assistance Gas Card Counseling

(to check, double click on box and click on checked)

Patient Information

Full Name of Patient: _____ Date of Birth _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Daytime Phone: () _____ Alternate Phone: _____

Marital Status: _____ Social Security No.: _____ # of People in Household: _____

Patient's Place of Employment: _____

Other Household Members Place(s) of Employment: _____

Please list name of additional person that we may speak to regarding your application: _____

Screening or Diagnosis/Treatment Information

Cancer Type: _____ **Approximate Date of Diagnosis:** _____

Physician Name(s): _____

Please check all treatment types that apply:	Chemo <input type="checkbox"/> Date: _____	Radiation <input type="checkbox"/> Date: _____	Surgery <input type="checkbox"/> Date: _____
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What medications are you taking on a regular basis:

Insurance and Financial Information

Do you have medical Insurance (including Medicare, Medicaid or private coverage)? Yes No

If yes, list provider: _____

If yes, does your insurance cover prescriptions? Yes No

Estimated Monthly Household Income (list all sources from those living in household—wages, unemployment, disability, other retirement, social security): \$ _____

Liquid Assets (checking/savings): \$ _____ Value of other Assets (home equity, cars, land, etc.): \$ _____

Monthly Expenses:	Housing: Rent <input type="checkbox"/> Mortgage <input type="checkbox"/> Amount: \$ _____	Food \$ _____
Utilities:	Gas: \$ _____ Electric \$ _____ Water \$ _____ Phone \$ _____	
Insurance:	Life: \$ _____ Homeowners: \$ _____ Auto \$ _____ Medical \$ _____	
Medical Expenses:	Medication: \$ _____ Dr./Hospital \$ _____	Car Payment(s): \$ _____
Credit or other Debt Payments:	\$ _____	Total: \$ _____

Reason for Request

Please explain how your cancer diagnosis has affected your financial situation:

Please briefly describe request for funds (please read policies and guidelines sheet to make sure request is applicable to Hope Cancer Resources' policies):

Amount of Request: \$

Please list other sources of assistance being sought/received so that we may appropriately provide referrals:

How did you hear about Hope Cancer Resources?

Disclaimer, Release and Signature

I attest that I have read the policies and guidelines for Hope Cancer Resources patient assistance program. Furthermore, I certify that my answers on this application are true and complete to the best of my knowledge.

I hereby authorize Hope Cancer Resources to release or disclose my medical, demographic, and financial information only as necessary to those entities engaged on my behalf (i.e. pharmaceutical or insurance companies, mortgage or auto lenders, etc.)

I hereby authorize my physicians listed above to release or disclose medical, financial, and demographic information as necessary to Hope Cancer Resources in order to provide for my continuum of care and best access to resources.

I understand that false or misleading information in my application may require the return of patient assistance funds.

Signature: _____

Date: _____