Hope Cancer Resources
Support for the Journey. Education for Life.

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Patient Assistance Program

Through funds from the Arkansas Cancer Coalition, Cancer Challenge, Delta Dental, the Ozark Affiliate of Susan G. Komen for the Cure, the Winthrop Rockefeller Cancer Institute Auxiliary, the Walmart Foundation, Hope Cancer Resources Foundation, other private foundations and agency fundraisers, Hope Cancer Resources is able to provide assistance to patients living in or being treated in our four-county service area (Benton, Madison, Carroll and Washington). Assistance may be provided for emergency needs, including prescriptions. All requests must come to Hope Cancer Resources via our application; oral requests cannot be accepted.

It is our goal to provide a response to assistance requests in a timely manner. Please allow one business day for medication requests and up to 7 business days for other types of assistance.

The following requests for assistance will be considered:

- Medication (up to $500)
    - Must be directly related to cancer treatment
- 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
        - Utilities
    - Transportation needs such as
        - Car Payments
        - Gasoline (gas cards)
        - Travel needs for out of town treatment (hotel, airfare)

*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.

* While our maximum amount of assistance is $800, we cannot guarantee this amount for every patient. Generally, emergency assistance averages between $300 to $500. Requests for assistance are considered on a case-by-case basis. 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.

The mission of Hope Cancer Resources is to provide compassionate, professional cancer support and education in the Northwest Arkansas region today and tomorrow.

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Application for Assistance

Updated 12.22.16

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

Address: _____
Street *Apartment/Unit#*

_____
City *State* *ZIP Code*

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____

Marital Status: _____ Social Security #: _____-____-_____ Ethnicity: _____ Gender: _____

Patient's Place of Employment: _____ # of People in Household: ____

Other Household Members Place of Employment: _____

Additional contact: Name: _____ Relationship: _____ Phone #: _____

Cancer Type: _____ Date of Diagnosis: _____

Treatment Types: Chemo: ☐ Date: _____ Radiation: ☐ Date:_____ Surgery: ☐ Date: _____

Physician Name(s): _____

Do you have medical insurance? ☐ Yes, list provider:_____ ☐ No

If yes, does your insurance cover prescriptions? ☐ Yes ☐ No

Vehicle Information: Year:_____ Make:_____ Model:_____

Estimated Monthly Household Income
(Include all those living in household) $_____

Income Type: (Choose all that apply)
□ Wages □ Unemployment □ Disability □ Soc Sec □ Other:_____

Please briefly describe request for funds: (refer to policies and guidelines cover sheet)

_____

_____

_____

_____

_____

_____

***If you are <u>NOT</u> a patient at Highlands Oncology Group or Landmark Cancer Center, proof of diagnosis is required.**

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.

Patient Signature: _____ **Date:** _____

Name of person completing application if other than patient: _____

For Office Use Only

OSCAR ID# _____ Received Date: _____ Initials: _____ Entered Date: _____ Initials: _____