The Cancer Foundation
PO Box 49309
Athens, GA 30604-9309
(706) 353-4354

www.cfnega.org

The Cancer Foundation
SERVING NORTHEAST GEORGIA

The Cancer Foundation 2024 Program Application

Dear Applicant,

Thank you for your interest in The Cancer Foundation's Programs. The Cancer Foundation is a non-profit organization whose mission is to help alleviate the financial burden of cancer for eligible patients.

The forms enclosed are The Cancer Foundation's application for assistance. **Applications must be submitted/verified to The Cancer Foundation by a referring professional (i.e., your doctor, a nurse, social worker, patient navigator, or other health care professional involved with your care).** Please read the instructions carefully and fill out the application completely. Be sure to complete the income information. We use this information to understand your current financial situation thoroughly. Be sure to attach copies of the bill(s) you would like us to consider for payment and proof of income documents.

Referring professionals are asked to send the completed application to the following:

US Mail:

The Cancer Foundation
Attn: Client Intake
P.O. Box 49309
Athens, GA 30604-9309

Secure File Upload: https://bit.ly/TCFAssistance2024

Email: assistance@cfnega.org

Thank you again for your interest in The Cancer Foundation.

Financial Assistance Program (FAP):

Applicants must meet the following eligibility criteria to be considered for the FAP.

1. The applicant must have a cancer diagnosis as certified by a healthcare provider and a) be in active treatment or b) be receiving hospice care related to a cancer diagnosis. Active treatment includes chemotherapy, radiation therapy, hormone therapy, immunotherapy, or cancer-related surgery. Patients can apply during treatment or within six months following their last cancer treatment.
2. Reside in the TCF Service Area, which includes these counties of Georgia: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Jasper, Lumpkin, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rabun, Stephens, Taliaferro, Towns, Union, Walton, White, and Wilkes.
3. Have **household income** less than or equal to **250% of the Federal Poverty Guidelines**. https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
    - Must be able to provide proof of income for each person in the household over 17 years.

250% Federal Poverty Guidelines

Household Size	Gross Monthly Income	Gross Annual Income
1	$3,038	$36,450
2	$4,108	$49,300
3	$5,179	$62,150
4	$6,250	$75,000
5	$7,321	$87,850

*From the US Department of Health and Human Services
*Household is defined as any persons residing together related by blood, marriage, commitment, or legal adoption dependent on the combined income.

*Income limits are based on the household's **Gross** income before deductions.*

Required Documentation:

- Cancer Diagnosis Verification – The Referring Professional intake process verifies the cancer diagnosis information. *If additional verification is required, a letter from the client's oncologist/physician stating the diagnosis information will be requested.*
- Income Verification
    - If making wages, you **must** provide paystubs from the last **two** months or a statement from the employer (We cannot accept bank statements or tax returns as proof of income for wages. ONLY paystubs or statements from an employer are accepted).
    - If receiving income other than wages, please provide one of the following:
        - Bank statements from the last two months
        - Social Security Benefit Letter
        - Social Security 1099
        - A copy of a Social Security check
    - If a patient receives no income, please provide a letter stating the reason for no income.
- Proof of Residency in our Service Area
    - The applicant must provide one document or a government ID providing proof of residency. The documents must show the applicant's name and current residential address. P.O. Boxes do not prove residency. **The client's bills and income verification documents can prove residency if the physical address is visible, and the client's full name is on the provided document.**

Financial Assistance Program Guidelines:

- We do not reimburse. All Payments will be made directly to the company/vendor/creditor that is owed. Applicants must supply copies of the bill, late notice, mortgage statement, lease agreement, payment address, and phone number.
- Applicants may request up to **$750.00** per year.
- Applicants may reapply for financial assistance annually as long as they remain eligible.
- Applicants must be referred by a physician, physician assistant, nurse, social worker, patient account representative, patient navigator, or financial counselor.
- Only completed applications will be considered; a complete application includes the application form, supporting proof of income documentation, the referring professional payment request form, and copies/scans of all necessary patient bills to be paid.
- If more than one cancer patient is in active treatment within a household, each patient may receive $750 in assistance. **Assistance is offered per patient, not per household.**
- **Expenses Covered**: Financial assistance will be awarded to assist with these expenses.
    - ✓ **Housing:** rent/mortgage payments/security deposits/home insurance/property taxes
    - ✓ **Utilities:** gas, electric, water, propane, internet, and phone (we will cover the cost of cable television if combined with other utilities, but we will not aid in covering only cable television services.)
    - ✓ **Health Insurance Premiums** (COBRA included)
    - ✓ **Nutritional supplements** such as Boost, Ensure, Jevity, etc.
    - ✓ **Durable and consumable medical equipment or supplies** prescribed/recommended by a physician (i.e., lymphedema supplies, walkers, wheelchairs, bedside toilets, etc.)
    - ✓ **Transportation** assistance is available to aid clients in getting to their medical appointments. Clients may use all their assistance in the form of fuel cards in increments of $250. Only one fuel card will be sent at a time. A second and third gas card may be requested with at least 30 days between requests or if the previous gas card gets to $50 or below. Transportation assistance provided:
        - Fuel and Parking Assistance ($250 restricted fuel and parking p-cards)
        - Uber Health
        - Lyft Healthcare
        - Pre-Paid Bus Passes
        - Medical Transport Fees
        - Vehicle Loan or Lease Payments
        - Vehicle Insurance
    - ✓ **Funeral Costs**

Nutritional Assistance Program (NAP)

The Nutritional Assistance Program (NAP) is the newest program at The Cancer Foundation. NAP aims to provide clients with consistent and reliable food assistance.

Applicants must meet the following eligibility criteria to be considered for the NAP.

1. The applicant must have a cancer diagnosis as certified by a healthcare provider and a) be in active treatment or b) be receiving hospice care related to a cancer diagnosis. Active treatment includes chemotherapy, radiation therapy, hormone therapy, immunotherapy, or cancer-related surgery. Patients can apply during treatment or within six months following their last cancer treatment.
2. Reside in the TCF Service Area, which includes these counties of Georgia: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Jasper, Lumpkin, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rabun, Stephens, Taliaferro, Towns, Union, Walton, White, and Wilkes Counties.

Required documentation:

- Cancer Diagnosis Verification – The Referring Professional intake process verifies the cancer diagnosis information. *If additional verification is required, a letter from the client's oncologist/physician stating the diagnosis information will be requested*.
- Proof of Residency in our service area
    - The applicant must provide one document or a government ID providing proof of residency. The documents must show the applicant's name and current residential address. P.O. Boxes do not prove residency. The client's bills submitted for financial assistance can prove residency if the physical address is visible.
- The applicant will be required to take a food insecurity assessment created by the USDA.

Nutritional Assistance Program Guidelines:

- Clients will be invited to all of The Cancer Foundation's NAP Mobile Pantries
- All clients will receive updates and information about our partner mobile food pantries and other food bank services in their area.
- Clients living in Clarke, Barrow, and Jackson County are eligible for weekly deliveries from the food pantry.
- Clients living in Clarke County are eligible for Meals on Wheels services (limited availability and funding)

The Cancer Foundation Assistance Application

Applicant Type: ◯ New ◯ Renewal Application Date: _____

Applicant Information

Full Legal Name: _____

The name must match the one on the Government ID or Birth Certificate.

Preferred Name: _____ Date of Birth: _____

Gender: ◯ Male ◯ Female ◯ Transgender ◯ Non-binary/non-conforming

Race: ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ American Indian or Alaska Native ◯ White

Ethnicity: ◯ Hispanic, Latino, or Spanish Origin ◯ Not Hispanic, Latino, or Spanish Origin

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Additional Demographics: ☐ Homeless ☐ Disabled ☐ Veteran ☐ Active Military

Household Size: _____ Youth Dependents: _____

Total number of people in the household, including the applicant. *Total number of people 17 years old or younger in the household*

Physical Address: _____

City _____ State *Georgia* Zip Code _____ County _____

Mailing Address: _____

City _____ State *Georgia* Zip Code _____ County _____

Home Phone: _____ Mobile Phone: _____

Email Address: *(Required)* _____

Authorized Contact

Contact Name: _____ Phone Number: _____

Email Address: _____

Relationship with Applicant: ◯ Spouse/Partner ◯ Family Member ◯ Caregiver ◯ Friend

Client's Cancer Diagnosis & Treatment Information

What is your cancer diagnosis? _____ Diagnosis Date: _____

Are you currently receiving treatment? ◯ Yes ◯ No

Treatment Type: ☐ Chemotherapy ☐ Radiation ☐ Immunotherapy ☐ Hormone Therapy ☐ Surgery

The Cancer Foundation Assistance Application

Other Treatment Types: _____

Describe the other treatment(s) you are receiving.

If you are not currently receiving treatment, when was your last treatment? _____

Month and Year

Case Worker Name: _____ Treatment Facility/Practice Name: _____

Oncologists Name: _____ Facility/Practice Location: _____

City and State

Employment Information

Are you currently employed? ◯ Yes ◯ No

Employer Name: _____ Position: _____

Employment Start Date: _____ Employment End Date: _____

Monthly Household Gross Income – *Documentation to support reported income is required.*

Cash $ _____ Monthly Wages $ _____ Social Security $ _____

Disability $ _____ Unemployment $ _____ Retirement and Pension $ _____

Other Income $ _____ Welfare (TANF) $ _____ **Total Monthly Income** **$** _____

Assistance Requested - *Check all that applies.*

☐ Financial Assistance up to $750

The Financial Assistance Program supports clients with Housing Expenses, Utility Expenses, Transportation Expenses, Health Insurance or COBRA Premiums, Durable Equipment or Consumable Medical Supplies, Nutritional Supplements, and Funeral Expenses. *See our website for complete program details.*

☐ Nutritional Assistance

The Nutritional Assistance Program supports clients experiencing challenges purchasing food. *(Availability is subject to location. See our website for complete program details.*

Client Attestation

All the information I have provided is true and correct. I understand that any financial assistance the Foundation offers is paid directly to my creditors is limited and is based on the immediate needs that negatively impact my health status. Providing false information will result in denial of assistance.

I authorize the Foundation to contact the health care provider(s) listed above and authorize my health care provider(s) to release information related to this application to the Foundation. If requested by my health care provider(s), I will complete an appropriate authorization to allow them to release information about this application to the Foundation. All information provided to the Foundation will remain confidential, except that the Foundation may disclose information to my creditors and others as may be necessary to provide financial assistance.

I understand that although the Foundation may consider billing cycles and due dates when providing financial assistance, I remain fully responsible for the timely payments of my debts. I will indemnify and hold harmless the Foundation for any expenses, losses, or liabilities arising from or related to my obligations.

_____ _____

Applicant Signature Date

The Cancer Foundation Assistance Application

Referring Professional Payment Request Form

Referring Agency Name: _____ Request Date: _____

Client Full Name: _____ Date of Birth: _____

Assistance Request

☐ Financial Assistance
Housing Expenses, Utility Expenses, Transportation Expenses, Health Insurance or COBRA Premiums, Durable Equipment or Consumable Medical Supplies, Nutritional Supplements, and Funeral Expenses. See our website for complete details.

☐ Nutritional Assistance
Enroll the client in The Cancer Foundation's Nutritional Assistance program. A staff member will contact the client to perform an intake assessment. *(Subject to location)*

Transportation Assistance Additional Information

☐ Transportation Fuel & Parking Assistance
Formerly called Gas Cards. Limited to $250 per 30-day period for fuel and gas costs for medical appointments. Parking assistance is available to clients using Ramp cards.

☐ Lyft Healthcare Transportation Assistance
The client is limited to a $200 per 30-day period for transportation for medical appointments.

☐ Public Transportation Pre-Pay Assistance
Pre-payment for public transportation that is available in the client's area. Add the Public Transportation provider as a vendor below.

☐ Uber Health Transportation Assistance
The client is limited to a $200 per 30-day period for transportation for medical appointments.

Nutritional Supplement Additional Information *(Subject to retailer's availability.)*

Supplement Name: _____ Preferred Flavor: _____

Number of Cases: _____ Alternative Flavor: _____

Vendor #1 Information - *A copy of the client's bill must be provided to support the request.*

$ _____ _____

Amount Requested Payment Due Date

_____ _____

Vendor Name Client's Account Number

_____ _____ _____ _____

Payment or Shipping Address City State Zip

_____

Vendor Email Address *(To email payment notifications to the vendor.)*

_____

Additional Information or Payment Arrangements

Vendor #2 Information - *A copy of the client's bill must be provided to support the request.*

$ _____ _____

Amount Requested Payment Due Date

_____ _____

Vendor Name Client's Account Number

_____ _____ _____ _____

Payment or Shipping Address City State Zip

_____

Vendor Email Address *(To email payment notifications to the vendor.)*

_____

Additional Information or Payment Arrangements

The Cancer Foundation Assistance Application

Vendor #3 Information - *A copy of the client's bill must be provided to support the request.*

$

Amount Requested | Payment Due Date

Vendor Name | Client's Account Number

Payment or Shipping Address | City | State | Zip

Vendor Email Address *(To email payment notifications to the vendor.)*

Additional Information or Payment Arrangements

Vendor #4 Information - *A copy of the client's bill must be provided to support the request.*

$

Amount Requested | Payment Due Date

Vendor Name | Client's Account Number

Payment or Shipping Address | City | State | Zip

Vendor Email Address *(To email payment notifications to the vendor.)*

Additional Information or Payment Arrangements

Referring Professional Attestation

I reviewed the entire application and agreed with the need for funding. By applying on behalf of a client, I attest that I provided the client with a broad overview of The Cancer Foundation's Financial Assistance Program and its policies and that the client or their caregiver selected the requests I am submitting as their greatest need.

I verify that the client is in active treatment for a cancer diagnosis, is receiving hospice care related to a cancer diagnosis, or is within six months of their last cancer treatment as defined by the program guidelines.

I have no conflict-of-interest relationship with the client and solely represent the client's needs. *I am not requesting payment for services provided by my employer or an associated business owned by the referring agency.*

Full Name: _____ Signature: _____

Title: _____ Phone Number: _____

Email Address: _____