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Cancer Care, Inc.
275 Seventh Avenue
New York, NY 10001

ADMINISTRATION
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SERVICES
212 712 8080
1 800 813 HOPE (4673)

FAX
212 712 8495

E-MAIL
info@cancercare.org

WEB SITE
www.cancercare.org

March 15, 2004

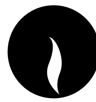
Dear Colleague,

Enclosed is Cancer*Care's* new financial assistance application. Please review it carefully and discard any previous applications. What distinguishes this application from previous ones is a section that the patient will ask you to complete and sign for them regarding their cancer diagnosis and treatment. Patients requesting financial assistance from Cancer*Care* will not be considered for this help without this information. Since the patient is the one disclosing his or her personal health information to us, there are no HIPAA implications.

You may fax or mail this form with **Attention to Social Service** on the fax cover sheet to 212-712-8495 or return it to the patient. *Please do not fax or mail to my attention or have patients contact me directly, this will slow down the process as all referrals need to be cleared through our database.* Please encourage your patients to complete all required information so this form can be returned as quickly as possible. Our funds are limited and based on availability.

Copies of this application can be obtained by calling 212-712-8080 or by downloading them from our website, www.cancercare.org. Cancer*Care* provides limited financial assistance for some medically related expenses. ***Please be aware that our grants are not for basic living expenses such as rent, mortgages, utility payments and food.*** Please visit our website for up to date information on our many disbursement programs, the availability of funds, and covered categories.

Sincerely,
Jane Levy
Jane Levy, CSW
Director of Patient Assistance Programs



CANCERcare®

275 Seventh Avenue, 22nd Floor, New York, NY 10001
Phone: 212-712-8080 or 1-800-813-HOPE Fax: 212-712-8495
Website: www.cancercare.org Email: info@cancercare.org

Financial Application

To Be Completed by Person Requesting Assistance

Personal Information

Name:______________________________ Date: ______________
Address: ______________________City/State/Zip: ______________
Phone: Home ( )______________Work: ( ) ______________
Date of Birth: ______________ Age: _______ Ethnicity ______________
❑ Male ❑ Female CancerCare # ______________

For CancerCare Use Only:

Social Worker: ______________ Case Manager: ______________

Health Insurance Information

Do you have health insurance? ❑ Yes ❑ No
If yes, please indicate type of insurance: (check all that apply)

❑ Medicaid
❑ Medicaid Pending
❑ Medicare Only
❑ Medicare plus Medicaid
❑ Medicare plus other supplemental coverage
❑ Breast and Cervical Ca Treatment Act
❑ Public Health Insurance
❑ VA Program
❑ Charity Care
❑ Emergency Medicaid

Are prescription drugs covered? ❑ Yes ❑ No

Financial Information

TOTAL Monthly Family Expenses: (Rent, Utilities, Childcare Transportation, Medical bills, Food)	$
TOTAL Family Savings: (IRA, CD's, Money Market, Stocks, Bonds)	$
TOTAL Monthly Family Income:	$

Currently Employed ❑ Yes ❑ No
Income Source (Please check all that apply):

❑ Social Security (retirement)
❑ Salary
❑ Pension
❑ Public Assistance
❑ In-Kind (room and board)
❑ SSI
❑ SSD (Disability)
❑ Alimony
❑ Sick Leave Pay
❑ Unemployment
❑ Short Term Disability
❑ Child Support
❑ Family/Friends provide support
❑ Other

Please continue to back of form

What Kind of Financial Assistance Are You Applying For? *Please be aware that our grants are not for basic living expenses such as rent, mortgages, utility payments and food. If you need this assistance one of our social workers may be able to refer you to a local agency that can help.*

❑ Transportation ❑ Child Care ❑ Home Care ❑ Pain Medications* ❑ Chemotherapy*
❑ Radiation* ❑ Other* *grants for these items are not available in all locations--see www.cancercare.org

What Other Cancer*Care* Services are you interested in?

❑ Individual Counseling ❑ Support Groups ❑ Educational Programs ❑ Referral to Resources

Signature____

Relationship to Person Applying for Help: ❑ Self ❑ Doctor ❑ Nurse ❑ Social Worker

To Be Completed by your Doctor, Nurse or Social Worker Only:

Medical Information

Date of Diagnosis:_____________ Primary Cancer: ______________________________

Stage of Cancer:_______________ ❑ New Diagnosis ❑ Recurrence

In Active Treatment? ❑ Yes ❑ No

If Yes, please indicate type of treatment (check all that apply):

❑ Chemotherapy ❑ Radiation ❑ Clinical Trial ❑ Surgery ❑ Hormonal

❑ Palliative Care ❑ Bone Marrow/Stem Cell Transplant ❑ Complementary/Alternative

If No, is Post Treatment Follow Up Needed? ❑ Yes ❑ No

If Yes, please indicate type of follow up:

❑ Yearly ❑ Every Six Months ❑ Other ____________________

MD Name: ____________________________Hospital/Clinic:________________________

Address: ____

City/State/Zip: ______________________ Phone: _______________Fax:_____________

Signature of person completing this section: ______________________________________

Print Name/Title:____

Phone (if different than above):____

Thank you. A Cancer*Care* social worker or case manager will review this information and contact the person requesting help. Funds are limited and based on availability. Please return form immediately. All information is strictly confidential and is for Cancer*Care* use only.