# PATIENT ASSISTANCE APPLICATION

*This application may be subject to a random audit of income and/or disease.*

Nebraska Cancer Specialists HOPE FOUNDATION

**Mail this application to: NCS Hope Foundation, 17201 Wright Street, Suite 200, Omaha, NE 68130**

**Please ensure you have included:**

1. Completed Application
2. Financial Verification (Income Tax Return, Social Security Award Letter, or most recent Pay Stub)
3. Health Statement signed by your Physician

If your income status changes, you must notify Nebraska Cancer Specialists Hope Foundation to determine whether or not you continue to qualify for assistance.

## APPLICATION INFORMATION

**New applicant:** ☐ Yes ☐ No **Renewal:** ☐ Yes ☐ No **If Renewal, when did you last apply?** Date: _____

**Services requesting:** ☐ Gasoline ☐ Housing Payment ☐ Car Payment ☐ Medical Supplies

**Who is filling out this application?** ☐ Patient ☐ Patient Representative

**If Representative, Name:**_____ **Relationship to Patient:** _____

## PATIENT INFORMATION

**Patient First Name:** _____ **Last Name:** _____

**Gender:** ☐ Female ☐ Male **Birth Date:**_____ **Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Street:** _____ **City:**_____ **State:**_____ **Zip:**_____ **County:** _____

**Home Phone: (**_____**)**_____ **Cell: (**_____**)**_____ **Email:** _____

**OK to Contact Patient?** ☐ Yes ☐ No **Best Time:** _____

**Alternate Contact:** _____ **Relationship to Patient:** _____

**Contact Phone: (**_____**)**_____ **Preferred Language:** ☐ **English** ☐ **Spanish** ☐ **Vietnamese** ☐ **Other** _____

**Are you Histanic, Latino, or of Spanish origin?** ☐ Yes ☐ No

**Ethnicity (Race:)** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____

**Gender:** _____ **Sexual Orientation:** _____

## LIST TOTAL HOUSEHOLD GROSS MONTHLY AMOUNTS FROM ALL SOURCES

**Salary $**_____ **Disability $**_____ **Unemployment/Work Comp $**_____

**Social Security $**_____ **Pension/Retirement $**_____ **Alimony/Child Support $**_____ **Other $**_____

**Total Household Gross Monthly Income $**_____ **Total Number Living in Household:** _____

## PROVIDER INFORMATION

**Facility/Practice Name:** _____ **Physician Name:** _____

**Street:** _____ **City:** _____ **State:** _____ **Zip:** _____ **County:** _____

**Phone: (**_____**)**_____ **Fax: (**_____**)**_____

**Number of Miles Traveled Round Trip for Each Visit:** _____

## INSURANCE INFORMATION

☐ **Private** ☐ **Medicare** ☐ **Military** ☐ **Medicaid** ☐ **Uninsured**

**Patient Signature**_____ **Date**_____

*Once a determination has been made, you will be notified by mail. The NCS Hope Foundation may ask at any time for further documentation to support a patient's eligibility, including after any grant has been extended. Any falsification of an application is fraudulent and subject to potential criminal penalties and civil damages.*

# HEALTH STATEMENT

***To be completed by a medical team member familiar with the patient's cancer treatment.***

## PATIENT INFORMATION

**Patient First Name:** _____ **Last Name:** _____

**Birth Date:**_____

## HEALTH STATEMENT

**(to be completed by a medical team member familiar with the patient's cancer treatment, certifying patient is currently undergoing cancer treatment)**

**Services requesting:** ☐ Gasoline ☐ Housing Payment ☐ Car Payment ☐ Medical Supplies

**Type of Cancer:** _____

**Number of Cancer Visits per Month:** _____ **Anticipated Length of Treatment:** _____

**Provider Representative Signature**_____ **Date**_____

**Printed Name**_____ **Title**_____

*I understand that Nebraska Cancer Specialists Hope Foundation will request only that information needed to process and administer this application. We will not disclose the information obtained except as needed for this purpose or as required by applicable law. I hereby represent, covenant and certify as follows that the information contained in this application is complete and accurate to the best of my knowledge. Nebraska Cancer Specialists Hope Foundation may revise, change or terminate the grant at any time.*

Mail to: Nebraska Cancer Specialists Hope Foundation, 17201 Wright Street, Suite 200, Omaha NE 68130

## APPLICATION APPROVED BY

**Printed Name**_____ **Title**_____

**Printed Name**_____ **Title**_____

Nebraska Cancer Specialists
HOPE
FOUNDATION

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HOPE FOUNDATION

## GRANT RESTRICTIONS

1. The foundation will assist all eligible, financially needy patients on a first-come, first-served basis, to the extent funding is available.
2. Patients will not be eligible for assistance unless they meet the Foundation's financial need eligibility criteria.
3. The foundation may ask at any time for further documentation to support a patient's eligibility, including after any grant has been extended. Any falsification of an application is fraudulent and subject to potential criminal penalties and civil damages.
4. In all cases, the patient will already be under the care of a physician with a treatment regimen in place at the time of application.
5. The foundation will make no referrals or recommendations regarding specific providers, practitioners, suppliers, products, or plans.
6. Patients will not be informed of the identity of specific donors.
7. The determination of a patient's financial qualification for assistance will be based solely on his or her financial need, without considering the identity of any of his or her healthcare providers, practitioners, suppliers, products, or insurance plan; the identity of any referring party; or the identity of any donor that may have contributed for the support of the patient's condition.
8. Assistance will be based upon a reasonable, verifiable, and uniform measure of financial need that will be applied in a consistent manner.
9. Patients are free at any time to switch providers, practitioners, suppliers, or products without affecting their continued eligibility for financial assistance.
10. Medicare beneficiaries are free to switch insurance plans when permitted by the Medicare program, without affecting their eligibility for assistance.

## HIPAA

When a patient completes an application, the patient is submitting personal health information that would be considered as "personally identifiable information" or "PHI" under federal law commonly referred to as HIPAA. The Foundation is not a "covered entity" as defined by HIPAA. Nevertheless, the Foundation seeks to adhere to the HIPAA "Security Rule" for purposes of securing the transfer and storage electronically of the patient's personal health information included in the application. Despite the attempt to protect such information, the Foundation cannot guarantee that there will be an unauthorized use or disclosure. If any unauthorized use of disclosure is brought to the Foundation's attention, the Foundation will attempt to contact the patient at the last address provided in an application.

## COUNTY REQUIREMENTS

You must be receiving oncology care in the state of Nebraska to be considered eligible.

| PERSONS IN FAMILY/ HOUSEHOLD | ANNUAL INCOME LIMITATION |
|---|---|
| 1 | $43,740 |
| 2 | $59,160 |
| 3 | $74,580 |
| 4 | $90,000 |
| 5 | $105,420 |
| 6 | $120,840 |
| 7 | $136,260 |
| 8 | $151,680 |

For families with more than 8 persons add $5,140 for each additional person x 300%.

**Nebraska Cancer Specialists Hope Foundation**
17201 Wright Street, Suite 200, Omaha NE 68130 • ncshopefoundation.org • (402) 334-4773

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