PATIENT ASSISTANCE APPLICATION

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

Nebraska Cancer Specialists
HOPE FOUNDATION

Submit completed applications via one of the following options:
Email: information@ncshopefoundation.org **Fax**: 402.691.1699
Mail: NCS Hope Foundation, 17201 Wright Street, Suite 200, Omaha, NE 68130
Please ensure you have included:
1. Completed Application
2. Copy or copies of Financial Verification (Income Tax Return, Social Security Award Letter, or most recent PayStub)
3. Copy or copies of Expense Verification (bills needing payment assistance)
4. Health Statement signed by a Provider Representative

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

APPLICATION INFORMATION

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

Services requesting: ☐ Gasoline ☐ Housing Payment ☐ Car Payment ☐ Medical Supplies ☐ Other: _____

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

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

PATIENT CONTACT INFORMATION

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

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell:** _____ **Email:**_____

OK to Contact Patient? ☐ Yes ☐ No **Best Time:** ☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☐ Early Evening

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

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

PATIENT DEMOGRAPHIC INFORMATION

Birth Date: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐ Another Gender ☐ Decline to Answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Two or more races ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to answer

Sexual Orientation: ☐ Straight ☐ Gay or lesbian ☐ Bisexual ☐ Something else ☐ I don't know ☐ Decline to answer

Insurance Type: ☐ Medicaid ☐ Medicare ☐ Medicare & Medicaid ☐ Medicare & Other ☐ Medicare & Private ☐ Military Program ☐ Private ☐ Uninsured ☐ Unknown ☐ Decline to Answer

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**: _____

If you do not have income documentation, you may complete and attach either the Statement of Support/Assistance Form or the Statement of No Income Form. Please visit the NCS Hope Foundation webpage for copies of these documents.

PROVIDER INFORMATION

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

Patient Navigator, Social Worker, or other Case Manager Name (if applicable):_____

Street:_____ **City:**_____ **State:**_____ **Zip:**_____ **Phone:** _____ **Fax:** _____

Number of Miles Traveled Round Trip for Each Visit: _____

SUPPLEMENTAL INFORMATION

How did you hear about NCS Hope Foundation?_____

Please briefly elaborate on your individual situation of need._____

_____

_____

_____

_____

_____

Would you be willing to have your story featured on our website and social media channels, with your photograph and/or a video for the purpose of helping others learn about our Foundation? ☐ Yes ☐ No

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 ☐ Other: _____

Type of Cancer: _____

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

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

Printed Name:_____ **Title**:_____

I understand that NCS 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. NCS Hope Foundation may revise, change or terminate the grant at any time.

Submit this form via one of the following:
Email: information@ncshopefoundation.org
Fax: 402.691.1699
Mail: NCS Hope Foundation, 17201 Wright Street, Suite 200, Omaha NE 68130

APPLICATION APPROVED BY

Printed Name:_____ **Title:**_____

Printed Name:_____ **Title:**_____

Nebraska Cancer Specialists
HOPE FOUNDATION

ELIGIBILITY & RESTRICTIONS

Nebraska Cancer Specialists
HOPE FOUNDATION

GRANT RESTRICTIONS

1. The foundation will assist all eligible patients in financial need 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.

GEOGRAPHIC REQUIREMENTS

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

FINANCIAL ELIGIBILITY CRITERIA

PERSONS IN FAMILY/ HOUSEHOLD*	ANNUAL INCOME LIMITATION
1	$58,320
2	$78,880
3	$99,440
4	$120,000
5	$140,560
6	$161,120
7	$181,680
8	$202,240

**For families with more than 8 persons, add $5,140 for each additional person x 400%.*