Heartland
CANCER FOUNDATION

# Patient Assistance Application

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

**Mail this application to:** Heartland Cancer Foundation, P.O. Box 5203, Lincoln, NE 68505

**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 Treating Provider and sent directly from the health center

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

New applicant ❑ Yes ❑ No Renewal ❑ Yes ❑ No If Renewal, when did you last apply? Date_____

Are you applying for the DigniCap scholarship? ❑ Yes ❑ No

Grant requested (choose one) ❑ Housing Payment ❑ Gasoline ❑ Car Payment

❑ Utilities: Gas/Heat, Water & Electricity ❑ I am solely applying for the DigniCap Scholarship

Who is filling out this application? ❑ Patient ❑ Person/Patient Representative

If Representative, Name_____ Relationship to Patient_____

How did you find out about the Foundation's Program?_____

## Patient Information

Patient First Name_____ Last Name_____ Age_____ Gender ❑ M ❑ F

Birth Date_____ Ethnicity_____ Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Street_____ Apt#____ 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_____

❑ I am a U.S. citizen or legal resident of the U.S.

## List Total Household Gross Monthly Amounts From All Sources (Includes spouses/life partners living in household)

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 (_____)_____

## Insurance Information ❑ Private ❑ Medicare ❑ Military ❑ Medicaid ❑ Uninsured

Number of Miles Traveled Round Trip for Each Visit _____

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# Grant Restrictions

Please read through and sign to complete application.

**1)** Patient must be a U.S. citizen or legal U.S. resident.

**2)** The foundation will assist all eligible, financially needy patients on a first-come, first-served basis, to the extent funding is available.

**3)** Patients will not be eligible for assistance unless they meet the Foundation's financial need eligibility criteria.

**4)** 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.

**5)** 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.

**6)** The foundation will make no referrals or recommendations regarding specific providers, practitioners, suppliers, products, or plans.

**7)** Patients will not be informed of the identity of specific donors.

**8)** 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.

**9)** Assistance will be based upon a reasonable, verifiable, and uniform measure of financial need that will be applied in a consistent manner.

**10)** Patients are free at any time to switch providers, practitioners, suppliers, or products without affecting their continued eligibility for financial assistance.

**11)** 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 reside in one of the following counties to be eligible.*

**Nebraska**: Adams, Boone, Buffalo, Butler, Cass, Clay, Colfax, Fillmore, Franklin, Gage, Greeley, Hall, Hamilton, Harlan, Howard, Jefferson, Johnson, Kearney, Lancaster, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Phelps, Platte, Polk, Richardson, Saline, Saunders, Seward, Sherman, Thayer, Valley, Webster and York.

| Persons in Family/Household | Annual Income Limitation |
|---|---|
| 1 | $40,770 |
| 2 | $54,930 |
| 3 | $69,090 |
| 4 | $83,250 |
| 5 | $97,410 |
| 6 | $111,570 |
| 7 | $125,730 |
| 8 | $139,890 |

*For families with more than 8 persons add $4,720 for each additional person x 300%.*

I understand that Heartland Cancer Foundation will request only that information needed to process and administer this application. I represent that the information contained in this application is complete and accurate to the best of my knowledge. I have read the Grant Restrictions, have no questions, and consent to these restrictions.

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

*Once a determination has been made, you will be notified by mail. 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.*

**Heartland Cancer Foundation | Compassionate Assistance**
P.O. Box 5203, Lincoln, NE 68505 • 402-261-9974 • Fax: 402-939-0315 • Rochelle@HeartlandCancerFoundation.org • HeartlandCancerFoundation.org

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# Health Statement

To be completed by treating provider.

## 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)

**Service requesting** ❑ Gasoline ❑ Housing Payment ❑ Car Payment ❑ Utilities

**Type of Cancer** _____

**Number of Monthly Cancer Visits**_____ **Anticipated Length of Treatment**_____

I certify the patient is under my care, as the treating provider for active cancer treatment, not ongoing cancer surveillance. Further definition of active treatment is when the patient's treatment affects standard activities of daily living.

**Treating Provider Signature (MD, DO, PA, APRN)**_____ **Date**_____

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

**The Health Statement must be completed by the Provider that is prescribing and/or administering your cancer treatment. It must be sent from the Provider by email, fax (with letterhead) or mailed directly from the office**

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