



## **Cancer Patient Information and Application for Aid**

Celebrate Life Cancer Survivor Network is a local non-profit organization made up of cancer survivors that are dedicated to helping other cancer patients in any way we can. Our funds are limited and all money raised stays local to help residents in our area. The financial costs associated with cancer can often be overwhelming. The average person spends \$8,500 in out of pocket costs in the first year after diagnosis. Even having health insurance doesn't guarantee you'll be able to afford treatment. It is best to start researching your options before a financial crisis develops. This information sheet lists various sources of financial assistance that are available to people with cancer. Check with each agency or organization to see if you qualify for help.

### **Government Assistance**

There are a number of federal and state programs that provide financial benefits to individuals and families. These benefits are primarily set up for low-income households, the elderly, and the disabled. Each has eligibility requirements. There are also programs administered through state governments that can help with health care related needs. Government assistance programs include:

#### **U.S. Department of Health & Human Services**

Information on public assistance and food stamps

Check phonebook for your local office

[www.hhs.gov](http://www.hhs.gov)

#### **U.S. Administration on Aging**

Benefits for older adults

800-677-1116

[www.eldercare.gov](http://www.eldercare.gov)

(Eldercare Locator finds resources in your community)

#### **Social Security Administration**

800-772-1213

[www.ssa.gov](http://www.ssa.gov)

## **Centers for Medicare & Medicaid Services**

800-633-4227

[www.cms.gov](http://www.cms.gov)

## **Pharmaceutical Patient Assistance Programs**

Programs and services offered differ among drug manufacturers but may include:

- Help with insurance reimbursement
- Referrals to co-pay relief programs
- Help with the application process
- Discounted or free medications for patients who do not qualify for other assistance

## **Partnership for Prescription Assistance (PPA)**

888-4-PPA-NOW (888-477-2669)

[www.pparx.org](http://www.pparx.org)

To see if the drug company that makes your medication has a patient assistance program, check its website. You can also ask your doctor or check with the Partnership for Prescription Assistance (PPA). PPA has a list of pharmaceutical programs and other resources for financial assistance.

In addition to needing help with managing the cost of medicines and treatment, people with cancer often need assistance with expenses like transportation, homecare and child care. A number of nonprofit organizations have useful programs or referral information to help with these and other practical needs.

## **Cancer Organizations**

### **American Cancer Society**

800-ACS-2345

[www.cancer.org](http://www.cancer.org)

### **CancerCare**

800-813-HOPE(4673)

[www.cancercare.org](http://www.cancercare.org)

## **General Organizations**

### **United Way**

[www.unitedway.org](http://www.unitedway.org)

## **Community Organizations**

Check your local phonebook under “social service agencies.”

### **Faith-based Organizations**

Included are Catholic Charities, Lutheran Social Services, Jewish Family Services, and others. Check your local phonebook for listings.

*The information presented above in this document is provided for your general information only. It is not intended as medical advice and should not be relied upon as a substitute for consultation with qualified health professionals who are aware of your specific situation. We encourage you to take information and questions back to your individual health care provider as a way of creating a dialogue and partnership about your cancer and your treatment.*

### ***What financial aid is available from CLCSN?***

- CLCSN provides limited financial assistance to cancer patients of all types of cancers to help with the costs of treatment related transportation, family support related expenses such as food costs in the form of local supermarket gift cards, travel costs in the form of gasoline gift cards and in some cases other family related expenses such as rent, mortgage and utility costs.
- CLCSN does not cover insurance related expenses such as deductibles and co-pays.

### ***Who is Eligible for financial aid?***

In order to be eligible you must:

- Have a diagnosis of cancer certified by an Oncology Professional.
- Be in active treatment for your cancer or be within one year of a diagnosis of remission.
- Be a full time resident of the Ossipee Valley, Mt. Washington Valley, or the Lakes Region areas. In some cases, exceptions may be made for bordering communities in Western Maine.
- Meet our financial requirement of 250% of the federal poverty guidelines.

### ***Where do I send the application?***

Application form (last two pages of this document) should be mailed to:

CLCSN  
PO Box 488  
West Ossipee, NH 03890-0488



## Application for assistance

Please print clearly

|                            |                      |
|----------------------------|----------------------|
| Last name _____            | First Name _____     |
| Street Address _____       | City _____           |
| State _____ Zip Code _____ | Phone # (Home) _____ |
| Email? _____               | (Cell) _____         |

\*\*\*The following section to be completed by your Oncology Nurse, Doctor, Social Worker or Hospital Patient Navigator only \*\*\*

|   |   |
|---|---|
| <b>Medical Information</b>  |   |
| Primary Cancer _____  | Date of Diagnosis _____                     |
| Current Stage _____   | Is patient in active treatment? (Y/N) _____ |
| MD Name _____   | Hospital/Facility Name _____                |
| <input type="checkbox"/> New Diagnosis  | <input type="checkbox"/> Recurrence         |
| Is patient in active treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| If not in active treatment how often is follow up? <input type="checkbox"/> Yearly <input type="checkbox"/> 6 Months <input type="checkbox"/> Other _____ |   |
| Please indicate type(s) of treatment received in the past twelve months (check all that apply)  |   |
| <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____            |   |
| Name of person completing this form (if different from above) _____   |   |
| Relationship to this individual   |   |
| <input type="checkbox"/> MD <input type="checkbox"/> Nurse <input type="checkbox"/> Social Worker <input type="checkbox"/> Hospital Patient Navigator     |   |
| Signature _____   | Date _____                                  |



## Cancer Survivor Network

### Application for assistance

**\*\*\*This section to be completed by patient or person requesting assistance\*\*\***

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

#### INSURANCE INFORMATION

Does the patient have health insurance?  Yes  No

If yes, what type of insurance? (Check all that apply)

Private Insurance  Medicare  Medicaid  Medicare plus Medigap  VA  Charity Care

Are prescription drugs covered?  Yes  No

#### FINANCIAL INFORMATION

Is patient currently employed?  Yes  No \* Number of people in household? \_\_\_\_\_

Are other family members employed or receiving income?  Yes  No

FAMILY INCOME SOURCES (check all that apply)

Salary  Pension  Disability income  Social Security Income (retirement)

Social Security Disability  Unemployment  Public assistance  Other  \_\_\_\_\_

\*TOTAL ANNUAL (FAMILY) INCOME \$ \_\_\_\_\_

By way of my signature, I attest the above information to be true and accurate:

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*This information is required to determine if you qualify under the 250% of the federal poverty level guideline. Incomplete information may result in your request form not being processed. Our funds are limited and will be granted based on availability and applicants meeting our requirement guidelines.