Atlanta Cancer Care Foundation, Inc.

Application for Patient Financial Assistance

Updated 8/2020

Thank you for your interest in the Atlanta Cancer Care Foundation (ACCF) Patient Financial Assistance program. ACCF's mission is to alleviate the financial burden felt by patients and families who are struggling financially because of a cancer diagnosis. To do this, the Foundation makes grants to assist eligible patients with their greatest financial needs.

In order to be eligible for a grant through the Patient Financial Assistance programs, an applicant must:

- Be at least 18 years old
- Live in, or receive treatment in, ACCF's 17-county service area (**Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale & Walton counties**)
- Have a cancer diagnosis, certified by a healthcare provider
- Be in active treatment for cancer, or have completed active treatment within the past 12 months, or have declined active treatment and been admitted to hospice care.

Grants are not made directly to the patient; checks are made payable to the company owed. Please attach a copy of the bill(s) the patient would like to have considered for assistance. Copies must show the name on the account, account number and service address (for utility bills). If a bill is not available when application is submitted, it may be submitted separately by either the patient or the referring professional; however, **we will not issue a check toward any bill until a copy of the bill is received**.

- Utility or mortgage bills can be accepted in the name of spouse, partner or caretaker living at the same address.
- For rent assistance, submit either a copy of lease agreement or letter from landlord verifying that patient is a tenant and including landlord's name, address and phone.
- We do not pay medical bills owed to the referring practice, facility or hospital.

Please note that applications must be submitted by a referring professional (i.e. the patient's doctor, nurse, social worker, or other health care professional). **The application must be filled out completely, including patient information, medical verification, and physician, referring professional and patient signatures.**

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RESET FIELDS

Application for Patient Financial Assistance
ALL SECTIONS MUST BE COMPLETED IN FULL
Fax completed application to (678) 348-7523
or email to courage@atlantacancercarefoundation.org
Updated 8/2020

PATIENT INFORMATION

Name: _____ **Date of Application:** _____

Street Address: _____

City/State/Zip: _____ County:_____

Phone Number: (____) _____ Alternate Phone Number (optional): (____) _____

Email address (optional): _____

If patient is currently unable to speak on the phone due to illness or hospitalization, **or is not an English speaker**, provide contact information for a friend or family member authorized by the patient to speak with us about this application:

Name: _____ Phone: (____) _____ Relationship: _____

Patient Gender: □ Male □ Female **Date of Birth:** _____ **Number of people in household:** _____

Marital status: □ Single □ Married □ Separated /Divorced □ Widowed **Minor children in the home?** □ Yes □ No

Employment status: □ Employed full-time □ Employed part-time □ Unemployed □ Retired □ Disabled

Source(s) of income: □ Wages/salary □ Unemployment benefits □ Pension □ TANF □ Social Security Retirement

□ Long Term Disability □ Short Term Disability □ SSI □ SSDI □ Child Support □ In-Kind (room & board)

□ Alimony □ Family/friends provide support □ Other: _____

Patient Insurance Status: □ Private Insurance □ Medicare □ Medicaid □ VA Benefits □ Uninsured

Is the patient's current need for financial assistance a direct or indirect result of cancer treatment? □ Yes □ No

Which type of expense is the patient seeking assistance with?

□ Utilities (electric, gas, propane, water, phone) □ Rent/mortgage □ Auto loan or insurance

□ Medical insurance premium/co-pays □ Prescription costs □ Durable medical equipment costs

□ Other – specify: _____

The information in this section is VOLUNTARY. It is not required to apply for a grant, and will not be used in determining whether a grant will be awarded. It is being collected to help ACCF demonstrate our impact when seeking funding for the PFA program, and information about a specific individual will not be shared.

Race: □ White □ Black/African American □ Asian □ American Indian/Alaskan Native
□ Native Hawaiian/Other Pacific Islander □ Middle Eastern/North African □ Other/Multi-Racial

Ethnicity: □ Hispanic/Latinx □ Non-Hispanic/Non-Latinx

Estimated total household income (from all sources): $_____ per □ week □ month □ year

Have you applied for assistance from other organizations? □ Yes □ No

If yes, please list the other agencies: _____

_____

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Patient Name: _____

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MEDICAL VERIFICATION – TO BE COMPLETED BY TREATING PROFESSIONAL

Type of cancer: _____ Date of diagnosis (Month/Year): _____

Please provide information about treatment below:

Chemotherapy	Radiation	Hormone Treatment	Surgery
Start date: _____	Start date: _____	Start date: _____	Date: _____
End date: _____	End date: _____	End date: _____	

If patient is not receiving active treatment, is he/she receiving follow up care? □ Yes □ No

Treating Professional_____ Practice/Facility/Hospital: _____

Practices or treatment facilities with multiple locations -- which location? _____

I affirm the diagnosis and treatment information presented in this application, and have no reservations concerning this patient's request for financial assistance from ACCF because of cancer-related financial toxicity.

Treating Professional Signature: _____ **Date:** _____

REFERRING PROFESSIONAL *(to contact for questions)*

Name & Title (PRINT CLEARLY): _____

Practice/Facility/Organization: _____

Contact information (phone and/or email): _____ _____

Referring Professional: If patient is not present to sign the application, you MUST read the statements below to the patient and obtain verbal consent, then initial here to indicate that you have done so: _____ (Initials of referring professional)

APPLICANT (PATIENT)

All of the information I have provided for this application is true and correct. I understand that any financial assistance provided by the Atlanta Cancer Care Foundation (ACCF) is limited to ACCF's funding guidelines at the time of application, and may be limited to one time only.

I authorize my healthcare provider(s) to release information to ACCF related to this application. I understand that information provided to ACCF will remain confidential, except that ACCF may disclose information to my creditors and others as may be necessary to provide financial assistance. I understand that I remain fully responsible for timely payments of my debts, and indemnify and hold harmless ACCF for any expenses, losses or liabilities arising from or related to my debts.

Signature of Applicant: _____ **Date:** ___/___/_____