



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. Copies of the bill(s) the patient would like to have considered for assistance MUST be attached. Copies must show the name on the account, account number and service address (for utility bills).

- 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.
- Requests for assistance with food costs or fuel costs do not require a bill to be submitted.

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 Treating Professional, Referring Professional and Patient signatures.**



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 12/2021

PATIENT INFORMATION

DATE OF APPLICATION: _____

Name: _____

Date of Birth: _____

Street Address: _____

City/State/Zip: _____ **County:** _____

Phone Number: (____) _____ **Alt. 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 Nonbinary Transgender Other

Marital status: Single Married Partnered Separated /Divorced Widowed

Number of people in household: _____ **Minor children in the home?** Yes No

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

Ethnicity: Hispanic, Latino, Spanish descent Not of Hispanic, Latino, Spanish descent

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

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

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

Long Term/Short Term Disability SSI or SSDI Public Benefits Alimony/Child Support Family/friends

Other: _____

Patient Insurance Status: Private Insurance Medicare Medicaid VA Benefits Uninsured

Does the patient qualify for financial assistance from their provider's office or treatment facility? Yes No

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

How would the requested financial assistance impact the patient and their financial situation? *(please check all that apply)*

Meet basic needs Reduce levels of financial stress Remove a barrier to treatment

Other: _____

FOR ACCF OFFICE USE ONLY:

Type of Assistance Provided: Food Assistance Housing Living Expenses Medical Expense

Transportation Utilities Other: _____



Patient Name: _____

Patient Phone: _____

Application for Patient Financial Assistance

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: _____
(Physician, Physician Assistant, Nurse Practitioner or Social Worker)

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: _____