partners in care

supporting the fight against cancer, together

Application For Financial Assistance

Please provide as much information as possible to assist our review.
Application should be completed in black ink.

Personal Information

First name _____ Last name _____

Date of birth _____

Address _____

Address line 2 _____ (optional)

City _____ State _____ ZIP _____

Primary phone _____ Alternate phone _____ (optional)

Email address _____

If the patient is under 18 years old, please provide the name of his/her parent or guardian:

Parent/guardian name _____

Demographic Info

Patient race

- ○ Caucasian
- ○ Black/African American
- ○ Asian
- ○ Native American
- ○ Hispanic
- ○ Other
- ○ Do not wish to answer

Patient employment

- ○ Employed
- ○ Unemployed
- ○ Disabled
- ○ Retired
- ○ Student

Patient sex

- ○ Female
- ○ Male

We're here to help. If you qualify for assistance, start by completing this application. Our professional staff will work with you so you receive the support you need without delay.

Step 1
Complete this application and email or fax it to us

Step 2
Our staff will then call you to determine your exact needs.

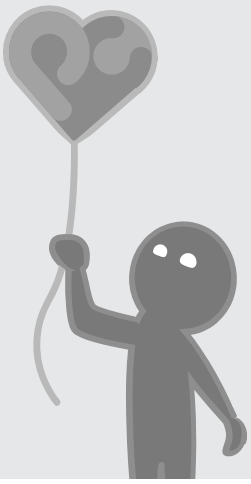
Step 3
Our staff will call your physician's office to verify the cancer diagnosis.

Step 4
Your application will go to our Financial Assistance Committee for approval.

Step 5
Once approved, you will be notified by phone or mail, and the requested assistance will be provided.

Eligibility

- ✓ Must be within 6 months of a cancer diagnosis
- ✓ Must reside or receive treatment in a state served by Partners in Care. Please call to check the availability of funds in your area.



Diagnosis Information

Diagnosis

- Brain cancer
- Bone/soft tissue/sarcoma
- Breast cancer
- Colon/rectal cancer
- Colonoscopy screening
- Esophagus cancer
- Genitourinary cancer *(bladder, kidney)*
- Gynecological cancer *(cervix, uterus, vagina, fallopian tube, vulva)*
- Head & Neck cancer *(tonsil, tongue, larynx, pharynx, nasal cavity)*
- Leukemia/lymphoma/myeloma
- Lung cancer
- Pancreas cancer
- Prostate cancer
- Other:

Other diagnosis (optional)

Date of diagnosis

Physician name

Hospital / clinic

Address

City

State

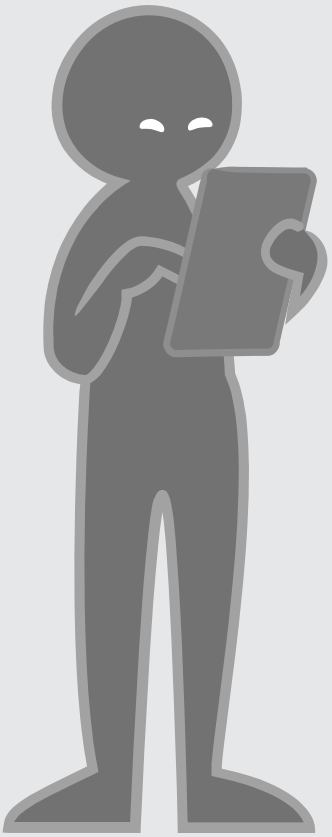
ZIP

Phone

Office contact name

Office contact phone

If you have any questions or need assistance completing this application, please call us at (239) 936-3756.



Assistance Categories

Please select the assistance needed from the categories below. *Note: We cannot provide assistance for prescription medications, deductibles, treatment expenses, mortgage/rent, utilities or other household expenses.*

Select one:

- ○ Medical supplies
- ○ Temporary lodging *(see right)*
- ○ Transportation
- ○ Food
- ○ Child care
- ○ Cancer screening
- ○ Respite care

Head & Neck cancer patients only:

- ○ Co-pay for treatment *(see below)*
- ○ Nutritional supplements *(see below)*
- ○ Compression garment
- ○ Trismus device
- ○ Dietician consultation

If you've selected Co-pay for treatment:

_____
Co-pay amount

If you've selected Nutritional supplements:

Please list supplements:

_____

_____

If you've selected Temporary Lodging:

Please provide three hotels/motels closest to your treatment facility center in order for staff to option the best nightly rate.

_____ _____
Hotel #1 name Phone

_____
Address

_____ _____ _____
City State ZIP

_____ _____
Hotel #2 name Phone

_____
Address

_____ _____ _____
City State ZIP

_____ _____
Hotel #3 name Phone

_____
Address

_____ _____ _____
City State ZIP

Note: reservations will be guaranteed for one night only. Additional nights will be provided as approved by the Financial Assistance Committee if the patient complies with hotel policies. It is the responsibility of the patient to keep any reservation that is made on their behalf. Failure to do so may result in all future reservations being forfeited indefinitely. If a cancellation is needed, this office must be notified one business day prior to check-in.

Notes:

_____

_____

_____

Financial Background

We are required to ask for applicants' financial information before providing support. Your information is stored securely, and will not be shared or sold.

Please attach a copy of the following documents:

- ○ Most recent tax return (first and second page only)
- ○ Wage or social security/disability statements
- ○ I do not file a tax return

_____
Household annual income

○ By checking this box, I am agreeing to receive additional communications from Partners in Care. This could include cancer education, information on cancer events and screenings, and/or future fundraising efforts. Partners in Care will not sell or rent your personal information. See our Terms and Privacy Policy, including Return Policy, at yourpartnersincare.org/privacy-policy. Please click "unsubscribe" on email communications to opt-out of e-mails.

By signing below I authorize Partners in Care to obtain and discuss information related to this application with my physician and other care providers. I certify that the above statements are true. Payment is dependent on availability of funds. Funds are not always available each month. All information related to this application will be kept strictly confidential and will not be shared with outside persons or agencies. Assistance will be awarded without regard to race, national origin, gender, or sexual orientation and may be suspended at any time due to unavailability of funds. Verification of information provided will be required. I hereby attest that I have been diagnosed with cancer within 6 months or I am in need of cancer screening and I am experiencing financial hardship. I understand that I may re-apply one time, after one year from the date of this application if a new cancer is diagnosed.

_____ _____
Signature Date signed

What happens next?

Send us your completed application:

Mail: 2234 Colonial Boulevard
Fort Myers, FL 33907

Fax: (239) 938-9399

Email: info@yourpartnersincare.org

↓

Your application will be reviewed within two business days. A member of our Care Team will contact you if additional information is needed.

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You will receive notification by phone, mail, or e-mail regarding the final status of your application.

↓

If approved, assistance will typically be provided within 72 hours.

If you have any questions or need assistance completing this application, please call us at (239) 936-3756.

FOR INTERNAL USE ONLY

- ○ Approved
- ○ Not approved

_____ _____ _____
Amount approved Explain Comments

_____ _____ _____
Physician's office contacted Date approved Approved by

○ Diagnosis verified _____ _____
Date approved Approved by

_____ _____
Date approved Approved by