Hope Cancer Resources
Support for the Journey. Education for Life.

5835 W. Sunset Ave., Springdale, AR 72762
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www.hopecancerresources.org

Financial Assistance Program

Eligibility Criteria

Applicants must:

- live in or receive treatment in our four-county service area (Benton, Madison, Carroll, Washington).
- have a confirmed cancer diagnosis; proof of diagnosis is required.
- demonstrate financial need related to a cancer diagnosis.

The following requests for assistance will be considered:

Short-Term Living Expenses
To be **eligible for financial assistance for living expenses, a**pplicants must be in **active** treatment or within one year of treatment completion. Active treatment is defined as chemotherapy (IV or oral), immunotherapy, radiation therapy, bone marrow or stem cell transplant, and/or surgery.
Examples of living expenses: rent, mortgage, utilities, homeowner's insurance, car payment, and/or car insurance.

Travel & Lodging Costs
Travel needs, such as hotel and air fare, for out of town consultations or treatment.

Supplemental Fuel Costs
Prepaid gas cards are provided to patients for travel to cancer-related appointments. Fuel costs are calculated based on vehicle type and mileage. Fuel is supplemental, we do not typically cover the full cost of a trip.

Medication
Need for medication must be directly related to the cancer diagnosis. Payment is made directly to a pharmacy.

Dental Care
Need for dental care must be directly related to cancer treatment. Confirmation from an oncology health care provider is required.

Transportation
Rides to cancer-related appointments and treatment. Must live in our four-county service area or no further than 60 miles one-way from appointment location.

Emotional Support
Individual, couples, caregivers, and/or family members may access mental health counseling services to address cancer-related concerns.

*It is our goal to provide a response to assistance requests in a timely manner. Please allow one business day for medication requests and up to 7 business days for other financial assistance requests.

The mission of Hope Cancer Resources is to provide compassionate, professional cancer support and education in the Northwest Arkansas region today and tomorrow.

Our Financial Assistance Program is supported in part through partnerships with the Arkansas Cancer Coalition, Cancer Challenge, Delta Dental, Northwest Medical Auxiliary, Hope Cancer Resources Foundation, as well as corporate and individual donors.

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Application for Assistance

Updated 1.2021

Name of Patient: _____ Date of Birth: _____
Last *First* *M.I.*

Address: _____
Street *Apartment/Unit#*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: _____ Social Security #: _____-____-_____ Gender: _____

Ethnicity: ❑ African American ❑ Asian ❑ Caucasian/White ❑ Hispanic ❑ Middle Eastern
❑ Native American ❑ Pacific Islander ❑ Other

Patient's Place of Employment: _____ # of People in Household:_____

Cancer Type: _____ Date of Diagnosis: _____

Treatment Types: ☐ Chemo: Date: _____ ☐ Radiation: Date: _____ ☐ Surgery: Date: _____

Physician Name(s): _____

Vehicle Information: Year: _____ Make: _____ Model: _____

Yearly Household Income:

❑ $0-$10,000 ❑ $10,001-$15,000 ❑ $15,001-$20,000 ❑ $20,001-$25,000
❑ $25,001-$30,000 ❑ $30,001-$35,000 ❑ $35,001-$40,000 ❑ Over $40,000

Insurance: ❑ Breast Care ❑ Medicare ❑ Medicaid ❑ VA ❑ Private ❑ Uninsured

Services requested: (choose all that apply)

❑ Living Expenses ❑ Travel/Lodging ❑ Fuel ❑ Medication ❑ Dental Care ❑ Transportation ❑ Counseling

Please briefly describe how cancer has impacted you financially:

_____

_____

_____

_____

***If you are <u>NOT</u> a patient at Highlands Oncology Group, proof of diagnosis is required.**

I attest that I have read the policies and guidelines for Hope Cancer Resources financial assistance program. Furthermore, I certify that my answers on this application are true and complete to the best of my knowledge.

I hereby authorize Hope Cancer Resources to release or disclose my medical, demographic, and financial information only as necessary to those entities engaged on my behalf (i.e. pharmaceutical or insurance companies, mortgage or auto lenders, etc.)

I hereby authorize my physicians listed above to release or disclose medical, financial, and demographic information as necessary to Hope Cancer Resources in order to provide for my continuum of care and best access to resources.

I understand that false or misleading information in my application may require the return of financial assistance funds.

Patient Signature: _____ **Date:** _____

Name of person completing application if other than patient: _____

**If signing electronically, you agree that your signature on this document is as valid as if you signed the document in writing.*

For Office Use Only

OSCAR ID# _____ Received Date: _____ Initials: _____ Entered Date: _____ Initials: _____