In keeping with Desert Cancer Foundation's mission to assist eligible residents of the Coachella Valley area with their cancer-treatment costs, the Board of Directors welcomes your application for financial assistance.

To be considered for assistance, you must fill out the application completely and submit all additional documents. Be sure to answer every question—DO NOT SKIP ANY QUESTIONS--and provide all items listed on the Application Checklist.

If you are approved to receive assistance, the date we receive your COMPLETE application will serve as your eligibility date. Total payments by Desert Cancer Foundation for your cancer treatment have a $50,000 lifetime limit.

Use to help prepare your application and keep for your records.

Application Checklist

Your application is complete when ALL required items listed below are received

_____**1.** A completed and signed **Application** for Financial Assistance.

_____**2.** Copies of **income tax returns** for the last two years, copies of all **bank statements** for the past three months, and copies of the **three most recent statements for all other accounts**, such as retirement accounts, investment accounts, annuities, etc. If taxes were **not** filed for the last two years, provide copies of all bank statements and other statements for the last six months and a written explanation why taxes were not filed. **Be sure to sign and date the statement.**

_____**3. Income verification**: For example: copies of paychecks or disability check stubs for the last two months, or copies of Social Security benefit statements, etc.

_____**4. Copies of application(s) and/or response letter(s)** from all programs to which applicant has applied, such as Medi-Cal, MISP, Breast & Cervical Cancer Treatment Program, etc.

_____**5. A signed release** allowing Desert Cancer Foundation to discuss applicant's health information with **medical providers**. **Release #1**

_____**6. A signed release** allowing Desert Cancer Foundation to discuss applicant's health information with **family and/or friends. Release #2**

_____**7.** For insured applicants (including Medicare and Medi-Cal), **a copy of the insurance card(s), front and back.**

Fill out and submit.

DESERT CANCER FOUNDATION
A California Nonprofit Public Benefit Corporation
74091 Larrea Street, Palm Desert, CA 92260
Phone: (760) 773-6554 Fax: (760) 773-6532

Application for Financial Assistance

1.Applicant's name _____ ☐ **Male** ☐ **Female**

2.Street address_____**(do not list P.O. Box unless homeless)**

3.Mailing address if different from street address _____

4. City_____**5. State**_____**6. Zip code**_____

7. Home phone_____ **8.Work/cell phone**_____

Additional contact name/phone_____**Additional contact name/phone**_____

9. E-mail _____ **10. Diagnosis**_____

11. Date of birth_____ **Age**_____**12. Social Security number**_____-_____-_____

13. If there are other people living in your household, fill out the section below:

	Applicant's spouse, partner, significant other or registered domestic partner	**Household Member**	**Household Member**	**Household Member**
First name				
Last name				
Date of birth/age	Dob Age	Dob Age	Dob Age	Dob Age
Relationship to applicant				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Marital status	☐ Single	☐ Single	☐ Single	☐ Single
	☐ Married	☐ Married	☐ Married	☐ Married
	☐ Registered domestic partner	☐ Registered domestic partner	☐ Registered domestic partner	☐ Registered domestic partner
	☐ Divorced	☐ Divorced	☐ Divorced	☐ Divorced
	☐ Separated	☐ Separated	☐ Separated	☐ Separated
	☐ Widowed	☐ Widowed	☐ Widowed	☐ Widowed
Employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of employer				
Disabled?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If disabled	☐ Temporary	☐ Temporary	☐ Temporary	☐ Temporary
	☐ Permanent	☐ Permanent	☐ Permanent	☐ Permanent

Fill out and submit. **Do not leave any blank spaces. Put "N/A" or "0" if applicable.**

14. PROVIDE INFORMATION ON HOUSEHOLD INCOME AND ASSETS:

INCOME	Total Household $ Amount	ASSETS	Total Household $ Value
Salary	Monthly	Residence	
Pension	Monthly	Real estate property	
Social Security	Monthly	Certificates of Deposit	
Disability	Monthly	Savings	
Unemployment	Monthly	Checking	
Worker's Compensation	Monthly	Retirement accounts (IRA, 401K, etc.)	
Alimony	Monthly	Year, make, model & mileage of car(s)	1. 2. 3.
Other (specify source)	Monthly	Other (specify)	
TOTAL		TOTAL	

15. PROVIDE INFORMATION ON MONTHLY HOUSEHOLD EXPENSES:

LIVING EXPENSES	Total Household $ Cost	MEDICAL EXPENSES	Total Household $ Cost
Food	Monthly	Medical insurance premiums	Monthly
Mortgage	Monthly	Doctor fees	Monthly
Property taxes	Circle one: Annual OR Monthly	Lab tests	Monthly
Rent	Monthly	Prescriptions	Monthly
Transportation (gas, insurance, loan payment, etc.)	Monthly	Other medical expenses (specify)	Monthly
Utilities	Monthly		
Other (Business expenses, credit cards, etc.)	Monthly	Other (specify)	
TOTAL		TOTAL	

Fill out and submit.

16. What is/was your occupation? _____

17. Are you currently employed? Yes No

18. If Yes, name of employer _____

19. If No, what was your last date of employment? _____

20. Are you eligible for COBRA medical insurance benefits? Yes No

21. Are you a U.S. military veteran? Yes No

22. If Yes, are you eligible for VA medical benefits? Yes No

23. Have you applied for Medi-Cal? Yes No

24. If Yes, application date_____**Application status**_____

25. Have you applied for MISP? Yes No

26. If Yes, application date_____**Application status**_____

27. Other programs applied for, dates & application status_____

_____

28. Are you eligible for Medicare? Yes No

29. If Yes,

30. Name of Medicare health plan (Senior Secure, SCAN, Secure Horizons, etc), if applicable):

_____

31. Monthly premium _____

32. Annual deductible _____

33. Do you have a Medicare prescription plan? Yes No

34. If you are not eligible for Medicare, do you have private insurance? Yes No

35. If Yes,

36. Name of insurance carrier _____

37. Monthly premium $_____

38. Annual deductible $_____

39. Are you covered by Medi-Cal? Yes No

40. If Yes, what is your monthly Share of Cost (SOC) $_____

41. Name of doctor managing your cancer care_____

42. Doctor's phone number_____

43. How were you referred to The Desert Cancer Foundation? _____

Fill out, sign, date and submit.

44. What type of assistance are you requesting for your cancer-treatment costs?

45. NO INSURANCE / Request assistance with all costs

46. INSURANCE / Request assistance with insurance premium

47. INSURANCE / Request assistance with co-pays / co-insurance / deductible

48. MEDI-CAL / Request assistance with Share of Cost

49. OTHER / Request assistance with:_____

(***must be directly related to cancer treatment***)

I verify all information provided in this application and accompanying documents is accurate and valid.

_____ _____

Applicant's signature **Date**

Read, sign, date and submit.

CRITERIA FOR ELIGIBILITY

Applicant must:

- **Be a resident of the Coachella Valley or surrounding communities and receiving cancer treatment in the Coachella Valley. (Out-of-area cancer treatment may be considered when referred by a local oncologist because the treatment is unavailable locally.)**
- **Have a valid Social Security number**
- **Have a cancer diagnosis confirmed by a licensed physician**
- **Provide documentation demonstrating financial need**
- **Request assistance limited to cancer treatment**

CONDITIONS OF PARTICIPATION

- **Financial assistance given will be paid directly to the provider of services.**
- **Providers must be in Desert Cancer Foundation's participating network.**
- **Benefits scope will be determined on an individual basis based on the client's needs.**
- **Updated application is required annually or upon request to assess eligibility.**
- **Eligibility decisions are subject to review by the Board of Directors**

CERTIFICATION, WAIVER AND RELEASE

I certify that the information contained in this application is true and correct and that I am a patient in need of financial assistance for medical care and treatment.

•By signing below, I hereby acknowledge that the Desert Cancer Foundation, including the Board of Directors, honorary board members, members, officers, volunteers, employees, and/or agents (collectively, "Foundation"), has sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that the Foundation is not obligated to make or continue such discretionary financial assistance payments to me or on my behalf. I understand and hereby acknowledge that the Foundation reserves the right to refuse or terminate any and all payments for any reason at any time and without notice. The Foundation shall not be liable for any injury, disease, death or other harm, which may result following any termination or refusal to provide financial assistance. I also understand and acknowledge that any financial assistance provided by the Foundation to pay for medical treatment, care, or prescriptions is not assignable and that any assignment thereof shall be void.

•By signing below, I hereby acknowledge that the Foundation is not responsible for any diagnosis, selection or appointment of physician(s) or medical treatment I require. In reviewing this application, the Foundation in no way shall be deemed to have issued a diagnosis of my medical condition or to have recommended treatment. Any evaluation of medical records is for the sole purpose of evaluating this application for financial assistance.

•By signing below, I hereby release, waive, and discharge the Foundation from any and all liability, and further covenant not to sue the Foundation, as a result of any medical treatment or refusal of treatment in any way associated with this application for financial assistance or which I may receive in conjunction with any funds provided by the Foundation. I hereby acknowledge that payments by the Foundation for medical care and/or treatment, including any payments for prescriptions, will not subject the Foundation to any liability for any injuries I may receive in connection with such treatment, care or use of prescriptions. I expressly release the Foundation from any and all liability under any cause of action in connection with any injury, disease or death resulting from the medical care, treatment and/or prescriptions I may receive. In the event of a dispute, the prevailing party shall be entitled to have and recover all costs and expenses, including all attorneys' fees. I expressly agree that this Certification, Waiver and Release is intended to be as broad and inclusive as is permitted by the laws of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I certify that I have read and voluntarily signed this Application and Certification, Waiver and Release, and agree that no oral representations, statements or inducement apart from what is contained in this application have been made.

Applicant's signature _____ **Date** _____

Fill out, sign, date and submit.
Release #1
This allows us to communicate with your medical providers.

AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom It May Concern:

For the purpose of continued medical care, I hereby authorize **Desert Cancer Foundation** and its representatives to discuss my Application for Financial Assistance (including but not limited to my financial information, diagnosis and treatment) and related medical care with physicians/medical providers (and their representatives) and social workers/financial counselors as needed.

I also authorize the release, as needed, of any medical records and information by my medical care providers to **Desert Cancer Foundation.**

_____	_____
Patient signature / Date of birth	**Witness signature**
_____	_____
Print name	**Print name**
_____	_____
Date	**Date**

Fill out, sign, date and submit.
Release #2
This allows us to communicate with your friends and family.
List their names below.

Authorization for Release of Protected Health Information

I hereby authorize_____
List names of persons authorized to discuss/release your health information
to obtain my information from and/or release my information to: **Desert Cancer Foundation**

This authorization is for full disclosure of all health care information.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that this revocation will not apply to information that has already been released based on this authorization.
If I do not specify an expiration date, event or condition, this authorization will expire in one year.
I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment.

Patient signature:_____

Patient name:_____ **Date of birth:**_____
(PRINT)

Patient Social Security no:_____ **Home phone:**_____

Cell/other phone:_____

Effective date:_____

Fill out and submit.

Tell us about your race This information is confidential and will only be used for grant applications and reporting.

What is your race? (Optional; check all that apply)

- ☐ White/Caucasian
- ☐ African American/Black
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ Other_____

Read and keep for your records.

DESERT CANCER FOUNDATION
ADOPTED POLICY FOR COST CAPITATION

(adopted by Board of Directors on 3/15/05)

I. Contingent upon availability of funds, Desert Cancer Foundation's Patient Assistance Policy is as follows:

A. Per-patient lifetime cap of $50,000 for cancer treatment for approved treatment plan. Emergency services and/or hospitalization not part of the approved treatment plan will not be covered.

1. A social worker/financial counselor at the facility where care is administered will assist the patient in applying for programs (i.e., MISP, BCCTP, Medi-Cal, etc.) that he/she may be eligible for at the beginning and during the course of treatment.

2. Applicant will be required to provide DCF with a response letter from all of the above programs he/she has applied to prior to initial approval of DCF financial assistance and any subsequent approvals.

3. A treatment plan and close cost estimate will be required from the patient's physician/provider. A letter will be sent to the physician/provider stating that the patient has applied to DCF and we are requiring a close cost estimate prior to approval.

4. Each applicant will sign a release allowing the DCF to discuss his/her care with the physician/provider and social worker/financial counselor.

II. All patients will be enrolled (if they qualify) in Pharmaceutical Patient Assistance Programs at the facility where care is administered.

III. Patients will be required to reapply for financial assistance every year or prior to your benefit expiration date.