HNC Living FOUNDATION
6240 W. 135TH STREET, SUITE 200
OVERLAND PARK, KS 66223
HNCLIVING.ORG

INDIVIDUAL APPLICATIONS

Please read before completing an application to determine your eligibility for assistance.

Criteria for consideration of financial assistance

- Applicant must be under active treatment for head and neck cancer or has undergone treatment for head and neck cancer by an established oncologist.
- Applicant must complete and submit the HNC Living Foundation Individual Application for Assistance.
- There is no current insurance coverage for requested expenses.
- Applicant must meet income qualifications (see below for income guidelines)

Not covered:

- Expenses not related to head and neck cancer treatment or recovery
- Expenses that can be paid for through other community resources (i.e., emergency assistance funds for rent or utilities, food pantries)
- Expenses that are covered by private insurance, Medicare or Medicaid
- Debt reduction
- Home modifications

Review of applications and payment of grants:

- Requests of less than $1,000 will be reviewed and financial aid determined within 10 business days of receipt of completed application and supporting documents. Requests of more than $1,000 will be reviewed and financial aid determined within 30 days.
- Payment will be made directly to service providers or vendors for future services. No cash payments will go directly to the patient.

Financial Guidelines

You must meet these financial guidelines to be considered for financial assistance. Your annual and/or monthly income (minus out-of-pocket medical expenses) must be at or below the following levels for the past 30 days:

Household/Family size	Annual income	OR	Monthly income
1	$37,470		$3,123
2	$50,730		$4,228
3	$63,990		$5,333
4	$77,250		$6,438
5	$90,510		$7,543
6	$103,770		$8,648

SUBMITTAL CHECKLIST:

Documents needed will vary depending upon the request.

All requests:

- ☐ Complete Application
- ☐ Medical order and/or letter from doctor (on letterhead) with requested treatment, medication, or equipment.
- ☐ Confirmation of head and neck cancer diagnosis from pathology report, progress notes or letter from doctor.
- ☐ Proof of income for the past 30 days.
- ☐ Letter of denial from the insurance company or policy showing exclusion, if applicable.
- ☐ Signed Consent to Release Information

Requests for travel, food or lodging:

- ☐ All documents listed in "All requests" above
- ☐ Letter of medical necessity from a social worker on letterhead stating the frequency and duration of treatment. Include a statement that insurance does not cover the request.

CONTACT INFORMATION:

For questions regarding your application or HNC Living Foundation, please contact us at:

PHONE: 913.402.6028

FAX: 913.498.9588

EMAIL: Jodi@hncliving.org

WEB: hncliving.org/for-patients/

Please email or fax the completed application and supporting documents to Jodi Wilson at Jodi@hncliving.org. Applications will be reviewed and assistance determined within 30 days of receipt of completed application.

HNC Living FOUNDATION

INDIVIDUAL APPLICATION FOR ASSISTANCE

Unless indicated, all fields are required

PATIENT INFORMATION:

Last Name _____ First Name _____

DOB (MM/DD/YYYY) _____ ☐ Male ☐ Female

Race *(optional)*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White ☐ Other

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

MEDICAL INFORMATION

Physician's name _____ Phone Number _____

Social Worker/Case Manager's name _____ Phone Number _____

Email of Social Worker/Case Manager _____

Clinical Diagnosis _____ Date cancer was diagnosed (MM/DD/YYYY) _____

Description of request _____

FUNDING INFORMATION

☐ Health Insurance (Private) ☐ Medicare ☐ Medicaid (state) ☐ None Number in Household _____

Monthly income (all sources – salary, SS, pension, unemployment, disability, etc.) $ _____

Monthly out-of-pocket **medical** expenses $ _____

How did you hear about HNC Living? ☐ Family ☐ Friend ☐ Social Worker ☐ Health Care Professional ☐ Internet ☐ Other

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I confirm that the information I have provided is accurate and true to the best of my knowledge.

Signature _____ Date _____

CONSENT TO RELEASE INFORMATION

I do hereby authorize all hospitals, financial institutions and insurance groups to release to HNC Living Foundation, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. In addition, I do hereby authorize all hospitals, financial institutions and insurance groups to release to HNC Living Foundation, or its duly authorized representatives, any information or itemized statements that pertain to the diagnosis and treatment and related expenses. I further authorize HNC Living Foundation and its representatives to provide such information to those institutions as may be reasonably required. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

In order for HNC Living Foundation, a not-for-profit organization, to advance supplemental financial support expenses in conjunction with the medical treatment of _____ the undersigned do hereby affirm as follows:

1. The undersigned is the patient.

2. The term "non-medical expenses" is understood to mean lodging, food, gas, parking and transportation for patients who require treatment and expenses incurred by the family of the above-named in conjunction with that patient's medical treatment. Financial assistance will be provided with the use of said funds to be specified by HNC Living Foundation.

3. The undersigned further agrees to return any unused funds immediately to HNC Living Foundation so that those funds can be utilized by the organization to benefit other families.

4. The undersigned acknowledges and agrees to maintain records that will be made available to HNC Living Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.

5. The information provided on the application form is true and correct to the best of my knowledge.

HNC Living Foundation reserves the right to distribute funds at its sole discretion. HNC Living Foundation may pursue restitution for grants if it is determined that the information submitted on the application is false.

When awarding a grant, HNC Living Foundation is not advocating for the specific health care providers or medical equipment suppliers, but only providing the funds to enable you to access the services and equipment. You acknowledge and agree that accepting a grant from HNC Living Foundation is strictly voluntary. Furthermore, you agree that you will be responsible for any choices you make regarding the medical care, equipment or supplies, or for the failure, malfunction, repairs or ongoing maintenance of any equipment obtained as a result of the grant of funds.

Date _____ County of residence (required) _____

Patient Signature _____ Print name _____

Patient/caretaker cell phone (required)* _____

**HNC Living Foundation will not sell or share your personal information; it will be kept in strict confidence. We only collect this information so we can contact you with questions or updates about your application.*

MEDIA RELEASE CONSENT

****Signing the media release form is not a requirement in order to receive assistance from HNC Living Foundation*

I hereby give my permission to HNC Living Foundation and/or its representatives to use photographs, audio tape recordings, letters, information or videotape of myself and to use our names, information, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet. I understand they will be used to inform families, volunteers, media, and the general public about HNC Living Foundation and its programs, services or events. I gladly give the authorization to support the efforts of HNC Living Foundation. I understand this authorization shall continue until terminated in writing.

Patient Signature _____ Print Name _____

Date _____