



8100 NEWTON STREET, SUITE 100  
OVERLAND PARK, KS 66204  
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. The application can be completed online here: [www.hncliving.org/for-patients](http://www.hncliving.org/for-patients).
- There is no current insurance coverage for requested expenses.
- Applicant must meet income qualifications (see page two 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, past due medical/dental bills, or costs incurred prior to application submission date.
- Home modifications.
- Bills incurred prior to date of application.

### **HNC Living Foundation can assist patients diagnosed with the following types of head and neck cancer:**

- |                           |                        |
|---------------------------|------------------------|
| ✓ Oral Cancer             | ✓ Nasal & Sinus Cancer |
| ✓ Salivary Gland Cancer   | ✓ Thyroid Cancer       |
| ✓ Throat Cancer           | ✓ Laryngeal Cancer     |
| ✓ Upper Esophageal Cancer |                        |

### **Eligible covered expenses after approval may include but are not limited to:**

- Co-pays and deductibles for appointments & treatments.
- Dental Care (pre-treatment and post-treatment).
- Gas Cards for appointments related to treatment.
- Nutritional Supplements.
- Doctor ordered and approved medical supplies & equipment not covered by insurance.
- Medication and prescriptions related to head and neck. Trained and board-certified medical oncologist.

Review of applications and payment of grants:

- Requests of less than \$1,500 will be reviewed and financial aid determined within 10 business days of receipt of completed application and supporting documents. Requests of more than \$1,500 will be reviewed by HNC Living Foundation’s Grant Committee 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. Household income is calculated for all members of the household.

Household Size	Income Threshold	Household Size	Income Threshold
1	\$31,225	5	\$75,425
2	\$42,275	6	\$86,475
3	\$53,325	7	\$97,525
4	\$64,375	8	\$108,575

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**SUBMITTAL CHECKLIST:**

*Documents needed will vary depending upon the request.*

**All requests:**

- Complete Application (online, secure fax, or email).
- 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.
- Documents to demonstrate financial need (Bank statement for last 3 months, government benefit award letter, pay-stubs, previous year tax returns, pension income).
- Letter of denial from the insurance company or policy exclusion, if applicable.
- If uninsured, Medicare or Medicaid letter of denial or letter of pending status.
- If applicable, copy of charity care or medical hardship application or letter of denial.
- 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 copy of treatment schedule.

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**CONTACT INFORMATION:**

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

**PHONE:** 913.402.6028    **FAX:** 913.498.9588    **EMAIL:** [applications@hncliving.org](mailto:applications@hncliving.org)

**WEB:** [hncliving.org/for-patients/](http://hncliving.org/for-patients/)

Please email or fax the completed application and supporting documents to HNC Living Foundation:[applications@hncliving.org](mailto:applications@hncliving.org).



## INDIVIDUAL APPLICATION FOR ASSISTANCE

*Unless indicated, all fields are required*

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### 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 \_\_\_\_\_

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### 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 \_\_\_\_\_

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### 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 \_\_\_\_\_

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## 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 \_\_\_\_\_

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