INDIVIDUAL APPLICATION

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
- 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 BEFORE application submission date
- Home modifications

HNC LIVING FOUNDATION CAN ASSIST PATIENTS DIAGNOSED WITH THE FOLLOWING TYPES OF HEAD AND NECK CANCER:

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

ELIGIBLE COVERED EXPENSES AFTER APPROVAL MAY INCLUDE BUT ARE NOT LIMITED TO:

- Co-pays and deductibles for appointments and treatments
- Dental care *(pre-treatment and post-treatment)*
- Travel costs, including gas cards, for appointments related to treatment
- Nutritional supplements
- Doctor ordered and approved medical supplies and equipment not covered by insurance
- Medication and prescriptions related to head and neck, trained and board-certified medical oncologist
- Oral nutritional supplements and enteral nutrition (tube feeding) during treatment

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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
1	$32,200
2	$43,550
3	$54,900
4	$66,250
5	$77,600
6	$88,950
7	$100,300
8	$111,650

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, paystubs, previous year tax returns, pension income)*
- ☐ Letter of denial from the insurance company or policy showing 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
- ☐ Letter of medical necessity from a social worker on letterhead stating the frequency and copy of treatment schedule.
- ☐ For travel requestsl, a letter of medical necessity from a health care professional and a copy of the treatment schedule showing all dates of treatment.

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 **WEB:** hncliving.org/for-patients/

Please email or fax the completed application and supporting documents to: applications@hncliving.org.

Mail Completed Application to: 8100 Newton Street, Suite 100, Overland Park, KS 66204

INDIVIDUAL APPLICATION FOR ASSISTANCE

Unless indicated, all fields are required

PATIENT INFORMATION

Last Name____________________ First Name____________________

DOB (MM/DD/YYYY)____________________ ☐ Male ☐ Female ☐ Unidentifying ☐ Prefer not to answer

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

Address____________________

City ____________________ State__________ Zip __________

Home Phone ____________________ Cell Phone ____________________

Email____________________

Caretaker or Support Person____________________

Caretaker or Support Person Email____________________

Caretaker or Support Person Phone____________________

Preferred Communication: ☐ Text ☐ Email ☐ Phone ☐ Caregiver ☐ Social Worker

Is the applicant currently or have they previously served in any branch of the armed service? ☐ Yes ☐ No

MEDICAL INFORMATION

Physician Name ____________________

Physician Phone Number ____________________

Social Worker/Nurse Navigator Name____________________

Social Worker/Nurse Navigator Phone Number____________________

Social Worker/Nurse Navigator Email____________________

Clinical Diagnosis____________________ Date cancer was diagnosed *(MM/DD/YYYY)*__________

Description of request ____________________

FUNDING INFORMATION

1. What kind of health insurance do you have? ☐Medicare ☐Medicaid ☐Private ☐None ☐Other:

   1b. If you don't currently have insurance, have you applied for Medicare or Medicaid?

   ☐ Yes, application pending ☐ Yes, I was denied ☐ No, but I'm planning to apply ☐ No, I am not planning to apply

2. Do you currently have dental insurance? ☐ Yes ☐ No

3. Number in household? ______________________________

4. Annual household income current year: $______________________________

   4b. Annual household income prior year: $______________________________

5. Last 30 Days of household income *(please list all sources: salary, pension, government benefits, etc.)* $______________

6. Last 30 Days of out of pocket medical expenses? $______________________________

7. Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Furloughed: ☐Other: ______________

   7b. If unemployed, when was the last date of work: ______________________________

   7c. Do you plan to return to work? ☐ Yes ☐ No ☐ Unknown

8. Have you received donations through personal fundraisers (GoFundMe, Facebook, or other charitable efforts)

   ☐ Yes ☐ No ☐ Unknown 8a. If so, please list the total income/assistance as of the application date $ ______________

9. Are you willing to submit pictures if requested for HNC Living Foundation's reports to funders? Yes No

STATEMENT OF ACKNOWLEDGEMENT

I hereby certify that the information I provided and any supporting documents are accurate, true, and correct to the best of my knowledge and belief. I understand that false claims may result in repayment of services and disqualify me from receiving any assistance from HNC Living Foundation in the future.

Applicant Signature: ______________________________ Date: ______________

Name of Person Completing Application: ______________________________