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 for appointments and treatments
- Dental care *(pre-treatment and post-treatment)*
- 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

REVIEW OF APPLICATIONS AND PAYMENT OF GRANTS:

- Requests of less than $2,500 will be reviewed and financial aid determined within 14 business days of receipt of completed application and supporting documents. Requests of more than $2,500 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	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8	$105,440

SUBMITTAL CHECKLIST:

Documents needed will vary depending upon the request.

All requests:

- ☐ Complete application pages 3-4 *(online, secure fax, or email)*
- ☐ *Signed consent to release information page 5*
- ☐ 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, current 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 applicable, copy of charity care or medical hardship application or letter of denial.

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/

Address: 8100 Newton, Suite 100, Overland Park, Kansas 66204
Please email or fax the completed application and supporting documents to: applications@hncliving.org.

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 ☐ Unidentifying ☐ Prefer not to answer

Race *(optional)*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White
☐ Middle East/North African ☐ 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 living 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. How did you hear about HNC Living Foundation? ☐ Family ☐ Friend ☐ Internet ☐ Social Worker
☐ Health Care Professional ☐ American Cancer Society ☐ Other: _____

10. Are you willing to submit pictures if requested by HNC Living Foundation 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: _____

HNC Living FOUNDATION

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 _____