INDIVIDUAL APPLICATION

Please read the information below to confirm your eligibility before applying

Criteria for Consideration of Financial Assistance:

- ✓ Applicants must complete and submit the HNC Living Foundation Individual Application for Assistance. We encourage applicants to use our online portal to ensure a more efficient application process. To apply online: https://www.hncliving.org/for-patients/
- ✓ Applicants must have a diagnosis of head and neck cancer confirmed by pathology.
- ✓ Applicants must demonstrate financial need and meet HNC Living's income qualifications.
- ✓ Applicants must provide physical or electronic documentation of their cancer diagnosis and financial documents. Additional records may be requested dependent on request type.

Qualifying Cancer Diagnoses:

- Oral Cavity (Mouth, tongue, palate, jaw)
- Pharynx (Throat, tonsil)
- Larynx (Voice box, glottis)
- Salivary Gland
- Nasal Cavity & Sinus
- Thyroid
- Upper third of Esophagus

  NOTE: The following are **not** considered head and neck cancers and do not qualify for assistance: Cancers of the brain or eye; skin cancers on the face or scalp; middle/lower esophagus cancers, including adenocarcinoma of the esophagus and gastro-esophageal junction.

Financial Guidelines:

Applicants must have a total household income of no more than 200% of the Federal Poverty Level to qualify. All household members over the age of 21 must submit their last 30 days of income:

Household Size	Income Threshold
1	$31,920 per year or $2,660 per month
2	$43,280 per year or $3,606 per month
3	$54,640 per year or $4,553 per month
4	$66,000 per year or $5,500 per month
5+	Add $11,360 per year for each additional household member

Types of Financial Assistance Grants:

- **Copayments** that are required at the time of appointment. Also covered are diagnostic imaging such as PET and CT scans.
- **Lodging,** treatment must be further than 50 miles one way and have more than two consecutive days of appointments.
- **Trach supplies, head garments and equipment** not covered by insurance.
- **Prescriptions** and over the counter medication related to head and neck cancer treatment, prescribed by a medical practitioner.
- **Oral nutritional supplements and tube feeding,** prescribed by a medical practitioner.
- **Dental,** we can assist with dental treatment plans in states where we currently have active grant funding. Please reach out if you would like to verify eligibility of your resident state before applying.

Ineligible Expenses Include:

- Costs unrelated to the diagnosis, treatment, or recovery of head and neck cancer.
- General living expenses, such as utilities, rent, mortgage, and groceries.
- Personal and home maintenance expenses, such as car repairs and home modifications.
- Health and dental insurance premiums, including Cobra payments.
- Medical and dental expenses incurred prior to the application submission date.

Application Submittal Checklist:

☐ Complete Individual Assistance Application pages 3 & 4.

☐ Sign the consent to release information on page 5.

☐ Provide confirmation of head and neck cancer diagnosis from pathology, progress notes, or letter from doctor on letterhead.

☐ Provide financial documents from everyone in the household: bank statements, government benefit award letter or paystubs from the past 30 days.

- If applicant and/or household members have no income, fill out the Zero Income Certification here: https://www.hncliving.org/zero-income/

Review of Applications and Payment of Grants:

- We are dedicated to supporting low-income individuals affected by head and neck cancer. Our program is focused on providing financial assistance to those in need and we serve all eligible clients without discrimination based on race, color, religion, sex, gender identity or expression, sexual orientation, age, national origin, disability, veteran status, or any other characteristic protected by law. Every applicant is treated with respect, dignity, and fairness, ensuring equitable access to our services and resources.
- We do not provide emergency approvals for applications. Our staff reviews, approves and provides grant payments to vendors within 14-21 days, depending on the request.
- Payments are made directly to service providers or vendors for future services.
- No cash payments will go directly to the applicant.
- Failure to provide supporting documentation requested by staff may result in longer approvals or denial of applicants' request(s).

INDIVIDUAL APPLICATION FOR ASSISTANCE

Patient Information:

Last Name _____ First Name _____

Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female ☐Prefer not to disclose

Race ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic/Latino

☐Middle East/North African ☐Native Hawaiian/Other Island Pacific Islander

☐ White ☐Other _____

Address_____ City _____

State_____ Zip _____ County _____

Cell Phone _____Email _____

Caregiver Name_____

Caregiver Phone_____ Caregiver Email _____

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

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

Medical Information:

Physician Name & Phone _____

Social Worker/Nurse Navigator Name _____

Social Worker/Nurse Navigator Email & Phone_____

Cancer Treatment Center_____

Diagnosis _____ Date of diagnosis (MM/DD/YYYY) _____

Assistance needed: ☐ Copays ☐Lodging ☐ Equip/Supplies ☐Prescriptions ☐Nutrition ☐Dental

☐ Other_____

Financial Information:

What kind of health insurance do you have? ☐ Medicare ☐ Medicaid ☐ Private ☐None

If you marked "None", have you applied for Medicaid? ☐ Yes, my application is pending
☐ Yes, I was denied ☐ No, but I am planning to apply ☐ No, I am not planning to apply

Do you currently have dental insurance? ☐ Yes ☐ No

Number living in household_____ Annual Household income prior year $_____

Last 30 days of household income (list all sources for all household members over 21) $_____

Employment Status: ☐Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Other _____

If unemployed, when was your last day of work? (MM/DD/YYYY) _____
Do you plan to return to work? ☐ Yes ☐ No ☐ Unknown

Have you received donations through personal fundraisers (GoFundMe, Facebook, or other charitable efforts)?
☐ Yes ☐ No If "yes", list the amount of donations you have received as of today $_____

How did you hear about HNC Living Foundation? ☐ Family ☐ Friend ☐ Social Worker ☐ Internet
☐ Health Care Professional ☐ American Cancer Society ☐ Other _____

Would you be willing to submit a note of gratitude and/or a picture of yourself for our funders if requested? Hearing directly from people like you helps our donors see the real-world impact of their support and is a critical part of our grant reporting: ☐ 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 (if not applicant) _____

Contact Information:

Email, Fax or mail the completed application (pages 3-5) and supporting documents to:

Fax: (913) 498-9588 **Email:** Applications@hncliving.org

Mailing Address: 8100 Newton St. Suite 100, Overland Park, KS 66204
Questions? 913-402-6028

CONSENT TO RELEASE INFORMATION (required):

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.

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

1. The undersigned is the patient.
2. 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.

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.

I have read the guidelines for financial assistance, and I declare that the information furnished on this application form, including attachments, is true and correct to the best of my knowledge.

Grant awards from HNC Living Foundation are intended solely to provide financial access to services and equipment, not to endorse specific providers. You acknowledge and agree that accepting a grant from HNC Living Foundation is strictly voluntary. Furthermore, you agree to take full responsibility for your health care decisions and for any equipment obtained, including its maintenance, repairs, or failures.

Patient Signature _____Date _____

**Your privacy is important. We only collect your information to contact you about your application and will not sell or share it with third parties.*

MEDIA RELEASE CONSENT

Signing the media release form is not a requirement 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 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_____ Date _____