**Diagnosis:** ________________

**Doctor:** ________________

# APPLICATION FOR ASSISTANCE

**Name of Cancer Patient**:________________________________________________

**Address:** ______________________________**City:**____________ **State:**____ **Zip:**_______

**Phone:** __________________________ **Email** ______________________________

**Occupation:** ______________________ **Employment Status:**______________________

**Spouse, Parent or Contact Person:** ____________________**Phone:**______________

**Occupation:** ______________________ **Employment Status:**______________________

**Number of Individuals Living in Household:** ________ **Ages:** ____________________

**Type Health Insurance:** Medicare ______ Medicare Supplement _______ Part D ________
Medicaid ________ Self-Pay _____ Private Insurance ____________

**ALL Monthly Household Income (after taxes):** *List all individuals currently contributing to your household income.*
Salaries: $____________ $____________ $____________
Social Security: $____________ $____________
Social Security Disability, Work Comp $____________
Pension/Retirement $____________
Other Income: $___________
Child Support: $___________
Interest, IRAs, Retirement Accounts: $___________
Additional income of all persons in home $_________
**Total All Household Monthly Income: $________________**

**Is A Change In Income Anticipated?** Yes____ No_____ If Yes, how much?________________

**Medicaid or DHHS Assistance?** Yes: _____ No: ____ Applying __________
If Yes, describe what you are receiving: Food Stamps: $_________ ADC: $__________
WIC: ______ Housing: ___________ Other: ______________________________

**Monthly Expenses: (Please Indicate Dollar Amounts)**

| | | | | **Insurance** | |
|---|---|---|---|---|---|
| Rent/Mortgage | ______ | Groceries/Household | ______ | Health | ____________ |
| Utilities | ______ | Total Credit Card Debt | ______ | House | ____________ |
| Phone | ______ | Monthly CC Payments | ______ | Car | ____________ |
| Television | ______ | Total Monthly Loan Payments | ______ | Life | ____________ |
| Gasoline | ______ | List Loans | __________________ | Other | ____________ |
| Medication | ______ | | __________________ | | |

Annual Out of Pocket Medical Obligation ______________________________________
Other Expenses: ____________________________________________________

**If needed please make notes or attach more information to clarify expenses/income* **(OVER)**

**Please Check Types of Assistance Requested:**

| | | | | | |
|---|---|---|---|---|---|
| Mileage/Gasoline | _______ | Lodging-Local | _______ | Car Payment | _______ |
| Groceries | _______ | Lodging-Out of area | _______ | Car Repair | _______ |
| Mortgage/Rent | _______ | Meals (if staying local) | ________ | Pharmacy-limited | _______ |
| Utilities | _______ | Transportation | _______ | Insurance-limited | _______ |
| | | *List Other Requests Separately* | | | |

I, the undersigned, attest that I have a cancer diagnosis. I acknowledge that my diagnosis will be verified with medical providers prior to assistance being offered. I, the undersigned, do authorize The Festival of Hope to allow Regional West Foundation to use my personal history when applying for funds from "The Festival of Hope" assistance fund. I authorize the Festival of Hope Board of Directors and its designee The Regional West Foundation to secure medical record information regarding my diagnosis and treatment needs and to verify with medical offices my requests for reimbursement and documentation of medical appointments. I authorize Festival of Hope to share and receive the application information with the Financial Assistance Department at Regional West Medical Center for verification purposes.

I agree the use of any facts pertaining to my personal life is at my risk and responsibility and The Festival of Hope nor its designee Regional West Foundation shall not be liable. I understand all information will be completely confidential and will be used only to determine eligibility for assistance.

I understand that original bills, receipts and fully completed mileage forms are required to be submitted prior to payment being rendered. I understand that it is my responsibility to follow through to get bills and other information to the Festival of Hope before payment or reimbursement can be processed. Festival of Hope may communicate directly with my landlord when rent assistance is requested. It is my responsibility to contact Festival of Hope if requests have not been fulfilled to ensure that all information has been processed. Proof of monthly expenses and income of all persons living in the household is requested.

Following approval of this application I will meet with the Festival of Hope Liaison to discuss financial options and the extent of assistance Festival of Hope will provide.

**Signature of Applicant or Guardian**: ____________________________________________________________
**Relationship to Applicant (if Guardian):** ______________________________ **Date:** ____________
**Witness:** __________________________________________________

**Send completed Application to:**

**Festival of Hope - Cancer Treatment Center**
**Attn: Jennifer Hiltgen**
**3911 Avenue B Suite G100**
**Scottsbluff, NE 69361**
**308-630-1348** Jennifer.Hiltgen@rwhs.org

**DO NOT WRITE BELOW THIS LINE**

Diagnosis: _________________________________________________________ verified: _____________
Physicians: _________________________________________________________ verified: _____________
Other information/Notes: ___________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Length of Time Assistance is Needed: _______________________________________________________

Approved: _____ Denied: ______ Reason for Denial: ____________________________________________

Signature of Festival of Hope Representative: _______________________________________

**Updated 1/2017**