Oneida Health Foundation

Cancer Care Support Application

Welcome to all cancer patients seeking support and assistance via the Cancer Care program at Oneida Health. We recognize the difficulties and uncertainties accompanying a cancer diagnosis and are dedicated to offering our support and assistance. Our program is designed to offer financial aid and resources to alleviate the challenges of treatment and recovery. We invite you to apply for and make use of the resources provided by the kindness of the Oneida Health Foundation. Remember, you are not alone on this journey; we are committed to supporting you at every step. Kindly review these guidelines before submitting your application.

To enroll in the Oneida Health program, you must have a cancer diagnosis and be a patient at Oneida Health. By applying, you authorize the Oneida Health Foundation to verify your status with our cancer specialists to confirm you are an Oneida Health patient. If you are not a patient at Oneida Health, we encourage you to explore applying through the Cancer Connects program.

To process your application, you must be verified as an Oneida Health patient by one of our medical providers and submit proof of income for everyone in your home. Lack of these documents could extend the review time or disqualify you from receiving aid.

Kindly submit the invoices or bills requiring payment. Originals are preferred, though clear readable photocopies or scanned copies are acceptable. Please note, we cannot accept photographs of the application, income proof, or bills.

Please be aware that we cannot reimburse patients for expenses already paid. Payments are made directly to the service provider or vendor.

If you wish to submit your application online, please visit:

https://ohc.formstack.com/forms/oneidahealthcancercareapp

All paper applications can be submitted through your physician's office to:

Foundation@OneidaHealth.org

Patient Name: ______________________________

Date of Birth: ______________________________

Address: Street ______________________________

Apt. # ______________________________

City, State, Zip ______________________________

Email: ______________________________

Phone: (   ) ______________________________

What is your cancer diagnosis? ______________________________

When were you diagnosed? ______________________________

How did you hear about our financial program? ______________________________

Name of your medical provider: ______________________________

Provider's phone number: (   ) ______________________________

Insurance Information

Do you have medical insurance? ○ Yes ○ No

	POLICY #1	POLICY #2
Insurance Provider(s)		
Group/Policy Numbers(s)		
Deductible Amount: $		
Out-of-Pocket Limit: $		
Annual Deductible?		

Annual Income Information

Total annual household income: ______________________

Number of people in household? ______________________

Number of children in the household and their ages? ______________________

Are you currently working? ○ Yes ○ No

Are you currently working? ○ Full Time ○ Part Time

Have you lost work due to your diagnosis? ○ Yes ○ No

Name of Employer: ______________________

Is anyone else in the home working? ○ Yes ○ No

Relationship: ______________________

What is their work status? ○ Full Time ○ Part Time

Name of Employer: ______________________

Please list/explain any retirement or disability you may receive: ______________________

What kind of support are you requesting?

○ Assistance with food expenses
○ Co-Pay assistance
○ Garment assistance
○ Assistance with gas/transportation expenses
○ Prescription assistance
○ Other financial assistance: please list below

____

Amount of financial assistance requested?
(Note: We cannot reimburse for bills already paid) ______________________

Reason for Request (please be specific and tell us what you need to use the financial assistance for):

____

Any special circumstances we should know about? (please attach an additional sheet if necessary):

____

Have you received assistance from the Oneida Health Foundation in the past? ○Yes ○No

If Yes... When? ______________________________

If Yes... How much and for what? ______________________________

Have you received assistance from any other organizations now or in the past? ○Yes ○No

- ○ Cancer Connects
- ○ Oneida Health
- ○ Angel Fund
- ○ Other: ______________________________

List of acceptable proof of income documentation

- Copy of most recent Federal Income Tax filing (page 1 & include page 2 if applicable of your 1040 form) *IMPORTANT: If you do not file Federal Income Tax forms, please note this on page 1 of the application
- If you are currently receiving Unemployment Insurance benefits, Disability benefits, or Workman's Compensation benefits, please submit a copy of your benefit letter.
- If you do not file an income tax return, please submit the following documentation, if applicable:
  - Copy of Medicaid / Social Services benefits statement
  - Copy of Social Security benefits statement
  - Copy of retirement fund and / or annuity statement

Please note that our financial assistance priorities are as follows in order of importance:

Medical bills not paid by insurance, co-pays, prescription drugs (related to cancer diagnosis), health insurance premiums & supplemental insurance premiums, medical garments & apparatus, gas & transportation for medical appointments, groceries & nutrition, wigs, non-medical necessary living expenses up to three (3) months while in active treatment.

We cannot pay for:

Tax bills of any kind, vendor bills where total owed is less than $10, auto loans where auto is already in repossession or payments are more than 1 month behind, premium cable bills items (such as pay-per view or movie rentals), auto insurance, household repairs not related to health/safety, legal fees, DMV fees, late fees, water bills, medical bills from a collection agency, fertility treatment bills, security deposits, or family members' medical bills

I understand that the Oneida Health Foundation will keep in extreme confidence any information provided by me and/or family members at all times. This statement covers medical status, personal or family life, and opinions expressed by me and/or family members. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself. In connection with this application, I hereby authorize my health care providers to disclose to the Oneida Health Foundation (collectively, the "Funders") the specific information requested on this form. This is for the purpose of determining my eligibility for the assistance I am seeking. I agree that any of my healthcare providers may rely on a copy of this authorization once signed below.

I understand that once my personal health information is received by any of the Funders, its confidentiality may no longer be protected under Federal Law. However, the Funders will not re-disclose this information to any other party. I understand that Oneida Health and the Oneida Health Foundation are separate entities.

______________________________ ______________________________

Applicant Signature Date

Please return your completed application with proof of income documentation to:

Mail: Oneida Health Foundation, 321 Genesee St., Oneida, NY 13421

Email with legible scan of documents to: Foundation@OneidaHealth.org

NOTE: We cannot accept photographs of applications or financial documentation.

If you need assistance completing the application, please contact our office at: 315-361-2169