



PATIENT ASSISTANCE POLICY GUIDELINES & APPLICATION

The Advocates for HOPE Foundation is a 501(c)(3) nonprofit organization which offers financial assistance to patients in the Greater Metro Area who are actively undergoing cancer treatment. The Foundation strives to relieve qualified patients of financial stress. The following are examples of day-to-day living expenses with which we may assist:

- **Rent or Mortgage payments**
- **Utility payments (water, sewer, electric)**
- **Telephone payments (landline or mobile)**
- **Transportation costs (car payments or insurance)**

Qualifications

In order to qualify, the patient and/or spouse must:

- **Be 18 years of age or older**
- **Be a legal resident of the United States**
- **Have an annual income at or below 300% of the national poverty level (see below)**
- **Be actively receiving treatment from a community oncology practice**

An Applicant may qualify for consideration based on a combination of the following financial criteria:

- **Have no more than \$5000 total in liquid assets (liquid assets are defined as cash, checking or savings accounts, stocks, etc.) for patients and spouse combined.**
- **Spouse or patient owns no secondary investment property.**
- **Income falls within the following guidelines:**

Funds Availability 2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline (300%)
1	35,010
2	47,190
3	59,370
4	71,550
5	83,730
6	95,910
7	108,090
8	120,270

The maximum amount of a grant per patient is \$1500 annually for debts incurred while actively receiving treatment. The Foundation reserves the right to suspend grant allocations based upon resources available.

Advocates for HOPE does not pay patient medical bills, co-payments, or credit card bills of any kind and does not provide direct patient cash grants. Upon approval, payment will be made directly to the creditor. No physician or staff member is eligible to receive any financial distributions from Advocates for HOPE. As funds are limited, Advocates for HOPE encourages all patients to create a plan for longer term support and assistance, and to contact additional community resources.

How to Apply

The Foundation application is accepted by fax at 844-AD4HOPE or email assistance@advocates4hope.com

For any additional questions, please contact the Foundation at 844-AD4HOPE. Please allow 21 days for application review and payment processing.



Section 1: PATIENT INFORMATION

Last Name _____ First Name _____

Address _____ City/Zip _____

Phone Home _____ Work _____ Cell _____

Email _____ Male Female Birth Date _____

Are you a legal resident of the United States? _____ Have you received help from our Foundation before? _____

Are you a patient of NSHOA? (If not, please provide a letter from your oncologist stating that you are currently undergoing treatment for cancer) _____

Number of persons living in your household including non-family and children _____

Section 2: FINANCIAL INFORMATION

EXPENSES

Monthly Family Expenses	Amount	Family Assets	Amount
Rent/Mortgage	\$	Checking	\$
Phone	\$	Savings and/or Money Market	\$
Home: Electric	\$	Investments	\$
Home: Gas	\$	Other (specify)	\$
Home: Water	\$	Family Assets Total	\$
Cable	\$		
Child Care	\$		
Transportation	\$		
Health Insurance	\$		
Medical Bills	\$		
Food	\$		
Other (specify)	\$		
Monthly Expense Total	\$		

INCOME PLEASE CHECK ALL THAT APPLY AND ATTACH COPIES OF INCOME DOCUMENTATION FOR EACH APPLICATION WITHOUT DOCUMENTATION WILL NOT BE PROCESSED

- Pension
 Public Assistance
 Short Term Disability/Sick Leave Pay
 Social Security (retirement)
 Child Support
 Alimony
 SSI/SSDI
 Unemployment
 Salary



1. To what other organizations have you applied for financial assistance? _____
2. Are you now or will you be receiving assistance from another organization(s)? YES NO
3. If YES, provide details and amount _____

PLEASE ATTACH THE FOLLOWING

- a. Copies of your **current** bills for items you would like to receive financial assistance. **Please continue to pay any bills until you receive notification of approval.**
- b. Verification of household assets- 3 months most recent bank statements for all accounts, and SSI letters for applicant, spouse and other household members living with you (if applicable). If no bank accounts or income, please include a notarized letter stating such.
- c. If requesting rent assistance, please attach copy of your rental agreement.
- d. If requesting mortgage assistance, please attach copy of your latest mortgage statement.

Household Expenses: Please list the expenses for which you are applying for assistance.

Item	Amount	Comments
AUTO		
RENT		
MORTGAGE		
UTILITY		
OTHER		

ADDITIONAL COMMENTS: _____

ONLY FULLY COMPLETED APPLICATIONS WILL BE PROCESSED



GENERAL RELEASE

I/We understand that our participation in the Advocates for HOPE Foundation is voluntary and these benefits are a humanitarian endeavor to provide financial support to patients who are battling cancer who are experiencing financial difficulties.

I/We release, discharge and agree to hold harmless Advocates for HOPE Foundation, its board, sponsors, employees and volunteers from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by the Advocates for HOPE Foundation.

I/We release authority to gather medical information and records requested as to my condition.

Last 4 digits of Social Security Number _____

Home Address _____

Signature _____

Print Name _____

Date _____