NEW YORK CANCER FOUNDATION

Advocates For Hope

The New York Cancer Foundation is a private 501(c)(3) nonprofit organization dedicated to helping cancer patients across New York State focus on their treatment by easing financial burdens.

Do I Qualify?

- Applicants must be 18 years of age or older.
- Applicants must currently be undergoing cancer treatment.
- Applicants must be citizens of the United States.
- Applicants must be residents of New York State.
- The annual gross income of household must be at or below 400% of the Federal Poverty Guidelines.
- The combined liquid assets of the applicant and their household, which include cash, checking and savings accounts, stocks, and similar financial resources, must not exceed $12,500.

Qualifying Annual Gross Income

2025 Federal Poverty Guidelines

How Many People Live In Your Household	Combined Annual Gross Income of Everyone Residing in the Household
1	$62,600
2	$84,600
3	$106,600
4	$128,600
5	$150,600
6	$172,600
7	$194,600
8	$216,600

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Documentation Checklist

To ensure the thorough review of your application, please submit the following required documents:

Documents Required for the Applicant:

- Complete the application form, ensuring that page 5 is signed.
- Provide a copy of your Driver's License or Non-Driver's License.
- Submit the Patient Treatment Verification Form (page 4), duly completed and stamped by your oncologist.

Documents Required for the Applicant and the Spouse or Significant Other:

- The most recent bank statement(s) for all accounts held in your name (*Examples: Cash, Bonds, Cash equivalents, such as checking and savings accounts, money market accounts, Stocks, Mutual funds, CDs (certificates of deposit).* Please include all pages and the last four digits of the account number.
- Documentation related to current income – (Examples of Acceptable Income Documents: *Two (2) most recent pay stubs, 2025 Social Security Award/Benefit Letter, Short-term or long-term disability statements, Pension account statement, Proof of government assistance (Example: SNAP budget letter), Unemployment Insurance report and/or Documentation of any other income (i.e., property leasing, spousal support)*

Please identify all applicable sources of income for both the applicant and the spouse or significant other, and attach the corresponding supporting documentation:

☐ Salary ☐ Public Assistance ☐ Short-Term/Long-Term Disability ☐ Alimony ☐ SSI/SSDI
☐ Unemployment ☐ Pension

Please provide a complete list of all individuals residing in your household (required).

Last Name	First Name	Relationship	Age	Employment Status
		Self		☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____
				☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____
				☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____
				☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____
				☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____
				☐Employed ☐Unemployed ☐Retired ☐Student ☐Other: _____

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PATIENT ASSISTANCE APPLICATION

Please Select Below the Category of Assistance You Are Requesting:

 ☐ Financial Assistance

 ☐ Transportation Assistance

☐ Both

Personal Information

Last Name: _____ First Name: _____

Date of Birth:_____ Gender: _____

Residence Address: _____ APT _____

Mailing Address : _____ ☐Same as Residence

City: _____ NY County: _____ State: _____ ZIP: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Other (specify):_____

Do you live alone? ☐Yes ☐ No

Number of Children under the age of 25 living in your household: _____

Do you prefer to be contacted by phone or email: ☐Phone ☐Email

Best Phone Number: _____ Best Email:_____

Are you a Citizen of the United States? ☐No ☐Yes Last 4 digits of SSN: _____

Do you need a translator? ☐No ☐Yes If so, please specify the language: _____

How did you hear about The NYCF?: ☐Oncology Practice ☐Internet Search ☐Past Grant Recipient ☐Friend/Family ☐Social Worker: (If you are being assisted by a social worker, please provide their name and contact information): _____

☐Other: _____

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Patient Treatment Verification Form

The Patient Treatment Verification Form must be completed by your oncologist or the office of your oncologist.
Please submit this to hope@nycancerfoundation.org OR fax to (631) 569-8519.

The form will not be accepted if it's completed by an applicant, a friend, a family member, or a non-clinical staff member

Patient Information:

First Name: _____ Last Name:_____

Date of Birth:_____

Oncologist/Surgeon Information:

Physician Name:_____ Name of facility:_____

Patient Treatment Information:

What is the patient's cancer diagnosis?_____ What stage (if applicable):_____

Has the patient received treatment for their diagnosis in the past?
☐Yes ☐ No

Is the patient currently under active cancer treatment?
☐ Yes ☐ No

Start of Treatment Date:_____ End of Treatment:_____

Is the patient going into treatment within the next three (3) months?
☐ Yes ☐ No

What type of treatment is the patient receiving? Check all that apply:
☐ Chemotherapy
☐ Hematopoietic progenitor cell transplantation
☐ Immunotherapy Radiation
☐ Hormone Therapy
☐ Surgery
☐ Radiation therapy
☐ Other: _____

Physician Signature:_____ **Date:_____**

NPI Stamp Here:

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Important Information

- **Application Requirements**
  - Applications cannot be processed without a completed Patient Treatment Verification Form, which must be stamped by the treating oncologist.
  - Applicants diagnosed with Stage I–III cancer must be actively receiving treatment at the time of application. Those diagnosed with Stage IV are not required to meet this treatment condition.
  - The application must be signed by the applicant. Unfortunately, we cannot accept signatures from social workers, family members, or other third parties.
  - All required documents must be submitted before the application can be reviewed. Once your file is complete, it will be evaluated and presented to the Board for approval.
- **Assistance Details**
  - The New York Cancer Foundation provides financial assistance of up to $2,500 to cover one (1) month of non-medical household expenses.
  - Please note that cash grants are not provided.
- **Rental Assistance Eligibility**
  - To be considered for rental assistance, you must submit one of the following:
    - A current rental billing invoice from your property management company along with your two most recent rent payment receipts, OR a copy of your lease along with your two most recent rent payment receipts.

  (Please note: cash rent payments are not eligible for assistance.)
- **Expenses NYCF Does Not Cover**
  - Unfortunately, the Foundation cannot provide assistance for the following:
    - Medical bills
    - Subscriptions
    - Credit card payments
    - Loans
    - Co-payments
- **Billing Information**
  - All bills must be in the applicant's name
  - Bills must be currently due or in arrears
  - Please do not send any bills with your application. Payments will only be made after the application has been approved.

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Important Information (Continued)

Financial Assistance Overview

- **Approved applicants may receive:**
  - Up to $2,500 to cover one (1) month of non-medical household bills (must be in the applicant's name).
  - Up to $750 in transportation assistance through Uber Health for oncology-related appointments.
- Assistance may be provided for the following bills in the applicant's name:
  - Rent or mortgage payments (applicant must be the lessee or homeowner)
  - Utility bills (water, sewer, electricity)
  - Phone bills (landline or mobile)
  - Cable or internet services
  - Car payments or car insurance
  - Storage unit fees
  - Life, homeowner's, or renter's insurance

****PLEASE NOTE:** To qualify for assistance, all storage units must be physically located within New York State, and all car insurance policies must be registered in New York State. Payments for storage units or car insurance outside of New York are not eligible for funding. **

- **Bill Payment Process**
  - Payments are made directly to the creditor. No payments will be made to the applicant.
  - All bills received by Tuesday will be reviewed, processed, and mailed out by Friday—unless we have any questions or require additional information.
- **Transportation Assistance (Uber Health)**
  - The New York Cancer Foundation offers up to $750 in transportation assistance via Uber Health, exclusively for oncology-related medical appointments.
  - Rides must be scheduled 1-3 days in advance of your appointment.
  - You'll receive ride confirmations and updates via text message or landline.

You can send your completed application and required documents by:
Mailing Address: New York Cancer Foundation - 20 Ramsey Road, Shirley, New York, 11967
Email: hope@nycancerfoundation.org
Fax: (631) 569-8519
Office Phone Number: (833) 588-6923

****Applications will NOT be reviewed for Board approval until ALL documents are received****

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I understand that my participation in applying for a New York Cancer Foundation grant is voluntary and these benefits are a humanitarian endeavor to provide financial support to patients who are battling cancer and are experiencing financial difficulties.

I release, discharge, and agree to hold harmless the New York Cancer 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 New York Cancer Foundation.

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

I understand not all recipients of the NYCF grant will use the full balance of $2,500 - the grant is **up to** $2,500 and is dependent on what each recipient has in their name.

I understand that if I am approved, I have **90 days** from the date of my approval to take advantage of the financial assistance portion of this grant before it expires.

I understand that my application will be discarded if it is not submitted with all the required documentation **within a six month time frame from the date of submission**, in which case I will have to reapply.

I understand that this application is for residents of **New York State** ONLY.

I acknowledge that if a payment is not received by the creditor, or is sent to an incorrect address due to inaccurate or incomplete information provided, the New York Cancer Foundation is not responsible for any stop payment fees incurred. Such fees will be deducted from the approved grant amount.

I attest that the information provided is accurate and truthful. I understand that I may be required to reimburse the New York Cancer Foundation for all or some of the monies granted, in the event that it is not truthful.

New York Cancer Foundation reserves the right to rescind the grants at any time based on withheld and/or false information at the discretion of the Board of Directors.

☐ I agree with all of the above.

Signature:_____ Date:_____

Print Name:_____

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