



NEW YORK CANCER FOUNDATION

Advocates For Hope

The New York Cancer Foundation wants to help if you need financial assistance with expenses, such as rent, mortgage, utilities, and transportation to and from your oncology appointments.

The [New York Cancer Foundation](#) is here for you.

Do I Qualify?

- Must be 18 years of age or older.
- Must be a United States citizen.
- Must have a cancer diagnosis.
- Must be a current New York State resident.
- Must have an annual income at or below 400% of the National Poverty Guideline.
- Must have no more than \$12,500 total in liquid assets (cash, checking or savings account, stocks, etc.) for patients and households combined.

Qualifying Annual Income

2025 Federal Poverty Guidelines

How Many People Live In Your House

Total Annual Income of All People Living in House

1	\$62,600
2	\$84,600
3	\$106,600
4	\$128,600
5	\$150,600
6	\$172,600
7	\$194,600
8	\$216,600



NEW YORK CANCER FOUNDATION

Advocates For Hope

How Do I Get Approved?

Submit the following documents to [The New York Cancer Foundation](#) as these documents are essential for processing your application.

The required documents for the applicant:

- Complete this application. Please be sure to sign page 5.
- Copy of a Driver License or Non-Driver License.
- Provide a letter signed by your oncologist on letterhead stating the cancer diagnosis.

The required documents for the applicant's, as well as for the spouse or significant other:

- Provide all pages of the statement(s) for the following accounts from last month's: savings, checking, stocks, credit unions, certificates of deposit (CD's), etc.
- Documents regarding current income. See below for examples.

Please provide the one(s) that apply to your family income:

- *Two (2) most recent pay stubs.*
- *A copy of the Award Letter that shows the Social Security benefits.*
- *Copy of Workers' Compensation benefits.*
- *Benefits for short-term and long-term disability.*
- *Pension account statement.*
- *Documents that show the amount and source of government income assistance, such as public assistance and SNAP benefits.*
- *A full report of the money you received from Unemployment Insurance.*
- *Additional Sources of Revenue (such as Property Leasing, Spousal Support, etc.).*

****Once all documents are received we will be able to review the application for Board Approval.****

How can I send my application?

Mailing Address: [New York Cancer Foundation](#)
[20 Ramsey Road](#)
[Shirley, NY 11967](#)

Email Address: hope@nycancerfoundation.org

Fax Number: [\(631\) 569-8519](tel:(631)569-8519)

If you have any questions, please call the Foundation at (833) 588-6923

*** REMEMBER TO SEND COPIES OF ALL DOCUMENTS***

NYCancerFoundation.org

40 Main St, Westhampton Beach, NY 11978

Phone: 1-833-588-6923



NEW YORK CANCER FOUNDATION

Advocates For Hope

PATIENT ASSISTANCE APPLICATION

Please select below the category of assistance you are requesting:

- Financial Assistance Transportation Assistance Both

Personal Information

Last Name: _____ First Name: _____

Residence Address: _____ APT _____

Mailing Address : _____

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

Date of Birth: _____ Gender: _____

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

Best contact phone number: _____

Best Email: _____

Are you a citizen of the United States? Yes / No Last 4 digits of SSN Only: _____

Do you need a translator Yes / No Please specify the language: _____

Oncologist Name: _____ Practice Name: _____

Cancer Diagnosis: _____

(Please provide a letter from your oncologist or surgeon that confirms your diagnosis of cancer)

Do you live alone? Yes / No

Do you have a caregiver or a family member that you would prefer us to speak with? Yes / No

If you would like us to communicate with your primary caretaker please provide:

(Name | Relationship | Phone #) _____

How did you hear about the New York Cancer Foundation? (We are always interested in learning how people found out about us.) Please check one: Oncology Practice Past Grant Recipient Internet search

Family/Friend Other: _____

PLEASE LIST ALL MEMBERS IN YOUR HOUSEHOLD

Last Name First Name Relationship Age Employment Status

Last Name	First Name	Relationship	Age	Employment Status
		Self		



NEW YORK
CANCER FOUNDATION
Advocates For Hope

We would love to hear your story. If you feel comfortable, please tell us about your journey so far.
(THIS IS OPTIONAL)

[Lined area for writing]

I give the New York Cancer Foundation consent to share my story



NEW YORK CANCER FOUNDATION

Advocates For Hope

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 recognize that in the event checks are not received by the creditor or sent to the incorrect location based on the information provided, the New York Cancer Foundation is not responsible for stop payment fees incurred and they will be deducted from the allotted grant monies.

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: _____

- The application must be signed by the applicant ONLY. Social workers, family members, or third-party signatures will not be considered. The applicant's signature is MANDATORY to process the application.
- Once all required documents are received, we will review your application for approval.
- The maximum grant amount per patient is up to \$2,500 for one (1) month of bills and up to \$750 for transportation.
- All bills must be in the Applicant's name and bill's must be currently owed or in arrears.
- New York Cancer Foundation is not permitted to pay patient medical bills, co-payments, or credit card bills of any kind and does not provide cash grants directly to patients.
- Upon approval, payments will be made directly to the creditor(s).
- Please note: Do not send any bills at this time, as we are unable to provide any payments until the application has been approved.



NEW YORK CANCER FOUNDATION

Advocates For Hope

FREQUENTLY ASKED QUESTIONS

Once I am approved, what should I expect?

- We will contact you via call or email.
- Will go over the bills that we are able to help with (see below for reference).
- Bills will be mailed out at the end of the week if we receive them by Tuesday of the same week.
- You will be able to reapply in 12 months from the month that you were approved in.

Once I am approved, what bills can I receive assistance with?

- Rent/Mortgage payments (patient must be lessee or homeowner)
- Utility payments (water, sewer, electric, etc.)
- Phone payment (landline or mobile)
- Cable or Internet payments
- Car insurance or payment
- Storage Unit payment
- Life insurance/ Homeowner's insurance/ Renter's insurance
- Property Tax

What bills does the New York Cancer Foundation NOT assist with?

- Medical Bills
- Credit Card Bills
- Co-Payments
- Tuition
- Subscriptions (newspaper, streaming services)

How are the bills paid?

- A check is written out and mailed directly to the creditor. Payments will NOT be made directly to the applicant

Once I am approved, how does the transportation grant work?

- The New York Cancer Foundation provides transportation assistance through Uber Health for up to \$750.
- The applicant will need to call us to set up their ride. Rides are only permitted to and from oncology-related appointments.
- Please call us 1-3 days prior to any oncology-related appointments in order to schedule transportation in a timely manner.
- You will receive notifications and updates regarding your rides through Uber Health over text and landline as they are scheduled.

What is Uber Health?

- Uber Health is a HIPAA-compliant technology solution that is designed to help patients get to and from healthcare appointments

What are the office hours for the New York Cancer Foundation?

- We are open Monday-Friday, 9 AM-5 PM