East Texas CANCER ALLIANCE of HOPE
LOCAL SUPPORT for LOCAL PEOPLE

Dear Applicant,

Thank you for your interest in East Texas Cancer Alliance of Hope (ETxCAH) Financial Assistance Program. EtxCAH is a non-profit organization designed to assist with the financial burden many individuals are faced with have been given a cancer diagnosis.

Enclosed is the ETxCAH application for assistance and instructions on how to complete this application. All applications will be brought before a committee and considered no matter the individual or family household income. ETxCAH has the right to deny services based on the discretion of the committee. ETxCAH does not discriminate on the basis of race, ethnicity, religion, sex, sexual orientation or age. Please note that all applications must be submitted to ETxCAH by a referring professional (i.e. your family doctor, oncologist, social worker, or other health care professional who is involved in your care). Please read the instructions very carefully and fill out the application completely. ETxCAH will require you to provide financial documentation to verify your income and expenses. ETxCAH will use the provided information to gain a complete understanding of your situation.

Please note, incomplete applications submitted by clients will not be reviewed which will delay any funds being released. Also, this application is not a guarantee for financial assistance and you remain responsible for your account balance.

Referring professionals are asked to print and mail this application to the address below or visit our webpage at www.etxcancerallianceofhope.org and submit an application.

Mailing Address
East Texas Cancer Alliance of Hope
P.O. Box 151114
Lufkin, TX 75915

Physical Address
East Texas Cancer Alliance of Hope
141 Turtle Creek Suite B
Lufkin, TX 75904

Thank you again for your interest in East Texas Cancer Alliance of Hope. If you have questions or concerns please give us a call at 936-899-7307 or email aberry@etxcancerallianceofhope.org

In Hope,

Ashley Berry
East Texas Cancer Alliance of Hope
Founder and CEO

East Texas CANCER ALLIANCE of HOPE

APPLICATION INSTRUCTIONS

ELIGIBILITY & GUIDELINES

Eligibility Requirements:

APPLICANTS MUST MEET THE FOLLOWING QUALIFICATIONS TO BE CONSIDERED FOR FINANCIAL ASSISTANCE.

To determine if you qualify, we require the following supporting documentation:

- Verification of Texas Residency in Angelina or Nacogdoches County
- Verification of Income and Assets
- Cancer Diagnosis certified by a healthcare provider
- Be in active treatment or within a three-month period of cancer treatment. Active treatments include chemotherapy, radiation therapy, or cancer related surgeries.
- Patient declines active treatment and is admitted to a hospice service.

Application Instructions:

1. Have a referring healthcare professional fill out and sign the professional recommendation
2. Fill out the client application completely.
3. Provide supporting documentation from the document list
4. Submit application and supporting documentation.

Email Application
info@etxcancerallianceofhope.org

Mail Application
East Texas Cancer Alliance of Hope
P.O. Box 151114
Lufkin, TX 75915

Submit in Person
East Texas Cancer Alliance of Hope
141 Turtle Creek Suite B
Lufkin, TX 75904

It is important that you complete this application and return it with all required documentation within 15 days. If you have difficulty completing this application or if you have additional questions, please call ETxCAH, Monday through Friday, from 9am to 4pm at 936-899-7307.

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DOCUMENT LIST

Client Financial Assistance Application Document List

IDENTIFICATION: (ONE REQUIRED)

1. ____Valid Texas Driver's License w/photo
2. ____Valid Texas Identification w/photo
3. ____Valid current U.S Passport or Passport Card w/photo
4. ____Valid current Permanent Resident Card (Green Card) w/ photo
5. ____Other valid current government issued photo ID

RESIDENCE PROOF: (ONE REQUIRED)

1. ____Deed or Property Tax Assessment in Applicant's Name
2. ____Lease in Applicant's Name
3. ____Military ID w/Texas Address
4. ____Non-Leasing Resident in Rental Unit (Notarized Letter)
5. ____Non-Leasing Resident in Homestead (Notarized Letter)

RESIDENCE INDICATOR: (TWO REQUIRED)

1. ____Valid Texas Driver's License or identification card w/photo
2. ____Texas Voter Registration Card
3. ____Bank Statements w/TX address - 6 most recent months (patient / spouse)
4. ____Unemployment compensation, Food Stamps, w/ TX address (patient / spouse)
5. ____Utility Bills in applicants name w/ TX address (Electric, Natural Gas, Water, Cable)
6. ____Letter/Card for a Texas County Indigent HealthCare Benefits (past 6 months w/TX address)
7. ____Notarized letter from Texas employer (on company letterhead) showing dates and location of employment
8. ____Proof of Texas public or private school or university enrollment for past six months

ASSETS: (ALL THAT APPLY)

1. ____Bank Statements; ALL Accounts (3 most current months) (patient / spouse)
2. ____If NO BANK ACCOUNT (complete Verification of No Bank Account Form)
3. ____Certificate of Deposit Statements (3 most recent months) (patient / spouse)
4. ____County Tax Appraisal for property other than Primary Residence
5. ____Securities Statements from last quarter (401K, Money Market, Stocks, Bonds, Etc) (patient / spouse)
6. ____Mortgage Statement for property other than Primary Residence
7. ____Most recent trust bank statement

INCOME: (ALL THAT APPLY)

1. ____Social Security (SSI or SSDI) Earning Statement or Social Security Award Letter (most recent) (patient / spouse)
2. ____Payroll Complete Check Stubs (3 most recent months) (patient / spouse)
3. ____Unemployment Compensation (patient / spouse)
4. ____Texas Workforce Wage History Report for (patient / spouse)
5. ____Family Support Letter

OTHER: (ALL THAT APPLY)

1. ____Proof / Verification of Current Insurance
2. ____County Indigent HealthCare Eligibility Determination Letter/ Card (most current)
3. ____MedData Eligibility Assistance Program (required call 713-563-0280)
4. ____Divorce Decree / Death Certificate
5. ____Proof of Health Insurance Marketplace Eligibility Determination

LOCAL SUPPORT for LOCAL PEOPLE

East Texas CANCER ALLIANCE of HOPE

HEALTHCARE PROFESSIONAL RECOMMENDATION

TO BE FILLED BY A HEALTHCARE PROFESSIONAL

PATIENT FULL NAME: _____ DATE OF BIRTH ____/____/____

ADDRESS: _____ PHONE _____-_____-_____

MEDICAL DIAGNOSIS: _____

WHAT ARE THE CIRCUMSTANCES CAUSING THIS FAMILY TO SEEK ASSISTANCE?

_____

_____

_____

_____

_____

IS THERE ANY INFO YOU CAN PROVIDE THAT WOULD ASSIST US IN HELPING THIS CLIENT?

_____

_____

_____

_____

_____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AGREE WITH THE FUNDING NEED.

REFERRING HEALTHCARE PROFESSIONAL NAME _____ DATE ____/____/____

ORGANIZATION _____ PHONE _____-_____-_____

SIGNATURE _____

PLEASE EMAIL THIS FORM TO INFO@ETXCANCERALLIANCEOFHOPE.ORG

OR

MAIL TO PO BOX 151114 LUFKIN, TX 75915

East Texas
CANCER ALLIANCE of HOPE

CLIENT APPLICATION

DEMOGRAPHICS

TO ENSURE PROMPT REVIEW OF YOUR APPLICATION, PLEASE COMPLETE ALL SECTIONS. DO NOT LEAVE BLANKS. YOU MUST SUBMIT DOCUMENTS TO CONFIRM YOUR IDENTITY, RESIDENCE, ALL INCOME AND ASSETS.

PATIENT FULL NAME: _____ **DATE OF BIRTH** ___/___/___

LAST FOUR OF APPLICANT'S SOCIAL SECURITY _____

◯ MALE ◯ FEMALE

◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED

ETHNICITY: ◯ ASIAN ◯ AFRICAN AMERICAN ◯ HISPANIC ◯ NATIVE AMERICAN ◯ WHITE ◯ OTHER

ADDRESS: _____

COUNTY _____ **PHONE** ____-____-_____ **EMAIL** _____

EMPLOYMENT:

◯ EMPLOYED ◯ SELF-EMPLOYED ◯ STUDENT DISABLED ◯ RETIRED ◯ UNEMPLOYED SINCE ____/____/____

◯ OTHER _____

HAVE YOU RECEIVED ASSISTANCE FROM EAST TEXAS CANCER ALLIANCE OF HOPE IN THE PAST? _____

HAVE YOU APPLIED FOR MEDICAID? Yes or No When? _____ Determination: _____

DO YOU RECEIVE STATE PUBLIC SERVICES SUCH AS TANF, BASIC FOOD, OR WIC? _____

DIAGNOSIS INFORMATION:

WHAT TYPE OF CANCER DO YOU HAVE? _____ DATE OF DIAGNOSIS ___/___/___

ARE YOU CURRENTLY RECEIVING TREATMENTS? _____ WHO IS YOUR ONCOLOGIST? _____

IF YOU ARE NOT RECEIVING TREATMENT, WHEN WAS YOUR LAST TREATMENT? ___/___/___

HOUSEHOLD INFORMATION:

FAMILY SIZE List family members in your household, including yourself. "Family" includes people related by birth, marriage or adoption who live together.

NAME	BIRTHDAY	RELATIONSHIP TO CLIENT	SCHOOL (IF APPLICABLE)	SHIRT SIZE	PANT SIZE	SHOE SIZE
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					
	____/____/____					

East Texas
CANCER ALLIANCE
of HOPE

CLIENT APPLICATION

EXPENSES AND INCOME

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation. **YOU MUST FILL OUT THIS SECTION COMPLETELY. Clients must be able to provide financial documentation regarding monthly income and expenses such as bills, bank statements, and social security income.**

Monthly Household Expenses:

Rent/Mortgage $_____

Insurance Premiums $_____

Car Payments $ _____

Medical Expenses $_____

Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, etc)

Household Income:

- ◯ Less than $10K
- ◯ $10K to $19,999
- ◯ $20K to $29,999
- ◯ $30K to $39,999
- ◯ $40K to $49,999
- ◯ $50K or more

INSURANCE INFORMATION:

DO YOU HAVE INSURANCE: YES OR NO NAME OF INSURANCE: _____ EFFECTIVE DATE ____/____/____

DO YOU NEED HELP FINDING INSURANCE COVERAGE? YES OR NO

PLEASE PICK THE CATEGORY THAT WILL BENEFIT THE CLIENT THE MOST. PLEASE CHECK ALL THAT APPLY.

- ◯ UTILITY BILLS: GAS, ELECTRIC, WATER
- ◯ GAS VOUCHERS
- ◯ NUTRITIONAL ASSISTANCE
- ◯ DURABLE MEDICAL EQUIPMENT
- ◯ INSURANCE CO-PAYMENTS
- ◯ MEDICATION NOT COVERED BY INSURANCE
- ◯ RESTAURANT VOUCHERS
- ◯ PARTIAL RENT/MORTGAGE PAYMENT
- ◯ LODGING EXPENSES

PLEASE LIST WHO THE CHECK SHOULD BE MADE PAYABLE TO

****NOTE** NO PAYMENTS ARE MADE DIRECTLY TO CLIENTS**

BILL #1

PAYABLE TO: _____ ATTENTION TO: _____

ADDRESS: _____ PHONE _____-_____-_____

ACCOUNT NUMBER: _____ AMOUNT REQUESTED $_____

BILL #2

PAYABLE TO: _____ ATTENTION TO: _____

ADDRESS: _____ PHONE _____-_____-_____

ACCOUNT NUMBER: _____ AMOUNT REQUESTED $_____

LIST OTHER AGENCIES YOU HAVE CONTACTED FOR HELP AND WHEN: _____

_____

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance.

Signature: _____ Date: _____/_____/_____